

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM

State New York

Citation  
45 CFR  
Part 201  
AT-76-141

As a condition for receipt of Federal funds under  
title XIX of the Social Security Act, the

New York State Department of Health  
(single State agency)

submits the following State plan for the medical  
assistance program, and hereby agrees to administer  
the program in accordance with the provisions of  
this State plan, the requirements of titles XI and  
XIX of the Act, and all applicable Federal  
regulations and other official issuances of the  
Department.

TN # 96-33

Supersedes

TN # 91-75

Approval Date NOV 04 1996

Effective Date OCT 1 1996

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State New York

SECTION 1 SINGLE STATE AGENCY ORGANIZATION

Citation  
42 CFR 431.10  
AT-79-29

1.1 Designation and Authority

(a) The New York State Department  
of Health

is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

TN 96-33  
Supersedes  
TN # 74-56

Approval Date NOV 04 1996

Effective Date OCT 1 1996



Revision: SWA-AI-80-33 (277)  
May 22, 1980

State New York

Citation  
Intergovernmental  
Cooperation Act  
of 1968

1.1(e) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

Not applicable. Waivers are no longer in effect.

Not applicable. No waivers have ever been granted.

IN # 79-9  
Supersedes  
IN # 74-56

Approval Date 7/26/79

Effective Date 4/1/79

HCFA-AT-80-38  
Revision: October 1996

5

State New York

Citation  
42 CFR 431.10  
AT-79-29

The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this Plan.

Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in Attachment 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

TR No. 97-10  
Supersedes 80-8  
TR No. 80-8

Approval Date: JUL 08 1997

Effective Date: OCT 01 1996

Revision: HCFA-AT-80-38 (RFP)  
May 22, 1980

State New York

Citation  
42 CFR 431.10  
AT-79-29

1.1(e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.

(f) All other requirements of 42 CFR 431.10 are met.

TN # 79-9  
Supersedes  
TN # 74-56

Approval Date 7/26/79

Effective Date 4/1/79



Revision: ~~EPA-AI-80-33 (BPP)~~  
May 22, 1980

State New York

Citation  
42 CFR  
431.50 (b)  
AI-79-29

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

The plan is State administered.

The plan is administered by the political subdivisions of the State and is mandatory on them.

IN # 74-25  
Supersedes.  
IN # 74-2

Approval Date 4/21/75

Effective Date 7/1/74

Revision: ~~SFA-AT-80-38 (SFP)~~  
May 22, 1980

State New York

Citation  
42 CFR  
431.12(b)  
AT-78-90

1.4 State Medical Care Advisory Committee

There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

IN # 74-2  
Superseries  
IN # None

Approval Date 12/31/74

Effective Date Prior to 1/1/74

Revision: HCFA-PM-94-3 (MB)  
 APRIL 1994  
 State/Territory: New York

Citation

1928 of the Act

1.5 Pediatric Immunization Program

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.
  - a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.
  - b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.
  - c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.
  - d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.
  - e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.
  - f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.
  - g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

TN No. **94-33**  
 Supersedes  
 TN No. **New**

Approval Date AUG 18 1994

Effective Date OCT 1 - 1994



Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

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45 CFR  
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assistance program, and hereby agrees to administer  
the program in accordance with the provisions of  
this State plan, the requirements of titles XI and  
XIX of the Act, and all applicable Federal  
regulations and other official issuances of the  
Department.

TN # 96-33  
Supersedes  
TN # 91-75

Approval Date NOV 04 1996

Effective Date OCT 1 1996

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938-

State: New York

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation  
42 CFR  
435.10 and  
Subpart J

2.1 Application, Determination of Eligibility and  
Furnishing Medicaid

- (a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

TN No. 91-76  
 Supersedes 75-57 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
 TN No. 75-57 HCFA ID: 7982E

Revision: HCFA-PM- - (MB)

State: New York

Citation  
42 CFR  
435.914  
1902(a)(34)  
of the Act

2.1 (b) (1) Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in ATTACHMENT 2.6-A.

1902(e)(8) and  
1905(a) of the  
Act

(2) For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.

1902(a)(47) and  
1920 of the Act

X

(3) Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.

42 CFR  
434.20

(c) The Medicaid agency elects to enter into a risk contract with an HMO that is--

y Qualified under title XIII of the Public Health Service Act or is provisionally qualified as an HMO pursuant to section 1903(m)(3) of the Social Security Act.

X Not Federally qualified, but meets the requirements of 42 CFR 434.20(c) and is defined in ATTACHMENT 2.1-A.

     Not applicable.

93-27

TN No.  
Supersedes  
TN No.

91-76

Approval Date

SEP 14 1993

Effective Date

APR 1 1993

Revision: HCFA-PM-91-3 (MB)  
October 1991

OMB No.

State/Territory: New York

Citation

1902(a)(55) 2.1(d)  
of the Act

The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(i)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

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TN No. <u>91-76</u>	Approval Date <u>MAR 3 1992</u>	Effective Date <u>OCT 1 1991</u>
Supersedes		
TN No. <u>91-64</u>		HCFA ID: 7985E

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

OMB No.: 0938-

State: New York

Citation  
42 CFR  
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

- Mandatory categorically needy and other required special groups only.
- Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.
- Mandatory categorically needy, other required special groups, and specified optional groups.
- Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

91-76

TN No.			Approval Date	<u>MAR 3 1992</u>	Effective Date	<u>OCT 1 1991</u>
Supersedes	<u>87-35A</u>					
TN No.						HCFA ID: 7982E

Revision: HCFA-PM-87-4 (BERC)  
MARCH 1987

OMB No.: 0938

87 3

State: NEW YORK

Citation  
435.10 and  
435.403, and  
1902(b) of the  
Act, P.L. 99-272  
(Section 9529)  
and P.L. 99-509  
(Section 9405)

2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

TM No. 87-35A  
Supersedes  
TM No. 86-29A

Approval Date MAR 26 1987

Effective Date JUL 0 1

HCFA ID: 1006P/0

Revision: HCFA-PH-87-4 (BERC)  
MARCH 1987

OMB No.: 0938-01

87 35

State: NEW YORK

Citation

42 CFR 435.530(b)  
42 CFR 435.531  
AT-78-90  
AT-79-29

2.4 Blindness

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

TN No. 87-35A

Supersedes

TN No. 76-22

Approval Date MAR 26 1990

Effective Date JUL 01 1990

HCFA ID: 1006P/0010

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

OMB No. 0938-

State: New York

Citation  
42 CFR  
435.121,  
435.540(b)  
435.541

2.5 Disability

All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in item A.14.b. of ATTACHMENT 2.2-A of this plan.

51-76

TN No. \_\_\_\_\_  
Supersedes \_\_\_\_\_  
TN No. 87-35A Approval Date MAR 3 1992

Effective Date OCT 1 1991

HCFA ID: 7982E

State: New York

Citation(s)

2.6 Financial Eligibility

42 CFR  
435.10 and  
Subparts G & H  
1902(a)(10)(A)(i)  
(III), (IV), (V),  
(VI), and (VII),  
1902(a)(10)(A)(ii)  
(IX), 1902(a)(10)  
(A)(ii)(X), 1902  
(a)(10)(C),  
1902(f), 1902(1)  
and (m),  
1905(p) and (s),  
1902(r)(2),  
and 1920

- (a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

Revision: HCFA-PM-86-20 (BERC)  
SEPTEMBER 1986

OMB-No. 0938-0191

State/Territory: NEW YORK

Citation

2.7

Medicaid Furnished Out of State

431.52 and  
1902(b) of the  
Act, P.L. 99-272  
(Section 9529)

Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

TN NO. 86-29A  
Supersedes  
TN NO. 82-24

Approval Date FEB 23 1990

Effective Date 10/1/86

HCFA ID:0053C/0061

Revision: HCFA-PM-94-5  
APRIL 1994

(MB)

State/Territory: New York

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

42 CFR  
Part 440,  
Subpart B  
1902(a), 1902(e),  
1905(a), 1905(p),  
1915, 1920, and  
1925 of the Act

3.1 Amount, Duration, and Scope of Services

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needed.

Services for the categorically needed are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and  
1905(a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

Not applicable. Nurse-midwives are not authorized to practice in this State.

\*Effective February 3, 1995  
nurse - midwife services will be known  
as midwife services in New York State  
per Education Law, Article 140.

**95-08**

TM No. \_\_\_\_\_  
Supersedes \_\_\_\_\_ Approval Date APR 25 1995 Effective Date FEB 3 - 1995  
TM No. 94-35

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation 3.1(a)(1) Amount, Duration, and Scope of Services:  
Categorically Needy (Continued)

1902(e)(5) of  
the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10),  
clause (VII)  
of the matter  
following (E)  
of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

TN No. 91-75  
Supersedes 90-27 Approval Date MAR 8 1991  
Effective Date OCT 1 1991

HCFA ID: 7982E

Revision: HCFA-PM-92-7 (MB)  
October 1992

State/Territory: New York

<u>Citation</u>	<u>3.1(a)(1)</u>	<u>Amount, Duration, and Scope of Services: Categorically Needy (Continued)</u>
	(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act	(vii)	Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	(viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act	(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.
1905(a)(23) and 1929	(x)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

TN No. 91-75 Supersedes 91-75 Approval Date MAR 23 1993 Effective Date OCT 1 - 1992

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy  
(Continued)

1905(a)(26) and 1934

  X   Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

TN No.: **02-01**  
Supersedes: **New**  
TN NO.: **New**

Approval Date SEP 03 2002

Effective Date JAN 01 2002

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR Part 440, (a)(2) Medically needy.  
Subpart B

This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv)  
of the Act

(i) If services in an institution for mental diseases or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of  
the Act

(ii) Prenatal care and delivery services for pregnant women.

TN No. 01-75

Supersedes 90-3

Approval Date M&D 1991

Effective Date OCT 1 1991

TN No.

HCFA ID: 7982E

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation 3.1(a)(2) Amount, Duration, and Scope of Services:  
Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

(vii) Services in an institution for mental diseases for individuals over age 65..

(viii) Services in an intermediate care facility for the mentally retarded.

42 CFR 440.140,  
440.150,  
Subpart B,  
442.441,  
Subpart C  
1902(a)(20)  
and (21) of the Act

TN No. 91-25  
Supersedes  
TN No. 87-47

Approval Date MAR 3 1992

Effective Date OCT 1 1991

HCFA ID: 7982E

Revision: HCFA-PM-93- 5 (MB)  
MAY 1993

State: New York

Citation

1902(e)(9) of  
Act

1905(a)(23)  
and 1929 of the Act

3.1(a)(2) Amount, Duration, and Scope of Services:  
Medically Needy (Continued)

- (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
- (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

93-27

TN No. 93-27 Approval Date SEP 14 1993 Effective Date APR 1 1993  
 Supersedes 92-71  
 TN No.

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1905(a)(26) and 1934

Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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02-01

TN No.:

Supersedes

TN NO.:

New

Approval Date SEP 03 2002

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Revision: ~~98-03~~ (1998)  
December 1997

State: New York

Citation

3.1 Amount, Duration, and Scope of Services

(a) (3) Other Required Special Groups:  
Qualified Medicare Beneficiaries

1902(a) (10) (E) (I)  
and clause (VIII)  
of the matter  
provided  
following (F),  
this  
and 1905(p) (3)  
of the Act

Medicare cost sharing for qualified  
Medicare beneficiaries described in  
section 1905(p) of the Act is  
only as indicated in item 3.2 of this  
plan.

1902(a) (10)  
(E) (ii) and  
1905(s) of the  
Act

(a) (4) (I) Other Required Special Groups: Qualified  
Disabled and Working Individuals

Medicare Part A premiums for  
qualified disabled and working  
individuals described in section  
1902(a) (10) (E) (ii) of the Act are  
provided as indicated in item 3.2  
of this plan.

1902(a) (10)  
(E) (iii) and  
1905(p) (3) (A) (ii)  
of the Act

(ii) Other Required Special Groups: Specified  
Low-Income Medicare Beneficiaries

Medicare Part B premiums for specified  
low-income Medicare beneficiaries  
described in section 1902(a) (10) (E) (iii)  
of the Act are provided as indicated in  
item 3.2 of this plan.

1902(a) (10)  
(E) (iv) (I) and  
1905(p) (3) (A) (ii),  
and 1933 of the Act

(iii) Other Required Special Groups: Qualifying  
Individuals

Medicare Part B premiums for qualifying  
individuals described in 1902(a) (10) (E) (iv)  
(I) and subject to 1933 of the Act are  
provided as indicated in item 3.2 of this  
plan.

TR No. 98-03

Supersedes

TR No. 93-27

Approval Date

MAY 15 1998

Effective Date

JAN 1 1998

NY 1997: 98-03  
January 1998

(continued)

State: New York

1902(a) (10)  
(E) (iv) (II), 1905 (p) (3)  
(A) (iv) (II), 1905 (p) (3)  
the Act

(iv) Other Required Special Groups: Qualifying  
Individuals - 2

The portion of the amount of increase to  
the Medicare Part B premium attributable  
to the Home Health provisions for  
qualifying individuals described in  
1902(A) (10) (E) (iv) (II) and subject  
to 1933 of the Act are provided as  
indicated in item 3.2 of this plan.

1925 of the  
Families  
Act

(a) (5) Other Required Special Groups:  
Receiving Extended Medicaid Benefits

Extended Medicaid benefits for  
families described in section 1925  
of the Act are provided as  
indicated in item 3.5 of this plan.

Revision: HCFA-PM-91- - (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation 3.1 Amount, Duration, and Scope of Services (Continued)

Sec. 245A(h)  
of the  
Immigration and  
Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

TN No. 91-75

Supersedes

TN No. 87-49

Approval Date

MAR 3 1992

Effective Date

OCT 1 1991

HCFA ID: 7982E

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

<u>Citation</u>	3.1(a)(6)	<u>Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)</u>
1902(a) and 1903(v) of the Act	(iii)	Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
1905(a)(9) of the Act	(a)(7)	<u>Homeless Individuals.</u>  Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) and 1920 of the Act	<input checked="" type="checkbox"/>	(a)(8) Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act	(a)(9)	<u>EPSDT Services.</u>  The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

TN No. 91-75

Supersedes

Approval Date

MAY 1

Effective Date OCT 1 1991

TN No. New

HCFA ID: 7982E

Revision: HCFA-PM-91-  
AUGUST 1991

(BPD)

OMB No.: 0938-

State/Territory: New York

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60

The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.

42 CFR 440.240  
and 440.250

(a)(10)

Comparability of Services

1902(a) and 1902  
(a)(10), 1902(a)(52),  
1903(v), 1915(g), and  
1925(b)(4) of the Act

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915 and 1925 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

- (i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.
- (ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.
- (iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.
- (iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

TN No. 91-75 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
Supersedes 87-47  
TN No. 87-47

HCFA ID: 7982E

A variety of methods are employed including -

- 1. review of enrollment and utilization data such as periodic reports.
- 2. validation by the New York State Department of Health of the provider's Quality Assurance Program through review of reports and on-site visits.
- 3. dissemination of information related to all individuals.
- 4. review of interview procedure.

Revision: ~~ETA-AT-80-38 (RFP)~~  
 May 22, 1980

State New York

Citation  
 42 CFR Part  
 440, Subpart B  
 42 CFR 441.15  
 AT-78-90  
 AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

- (1) Home health services are provided to all categorically needy individuals 21 years of age or over.
- (2) Home health services are provided to all categorically needy individuals under 21 years of age.

Yes

Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

Yes, to all

Yes, to individuals age 21 or over; SNF services are provided

Yes, to individuals under age 21; SNF services are provided

No; SNF services are not provided

Not applicable; the medically needy are not included under this plan

IN # 79-37  
 Supersedes  
 IN # 77-23

Approval Date 2/8/80 Effective Date 10/1/79

Revision: HCFA-PR-93-8 (BPO)  
December 1993

State/Territory: New York

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR 431.53

(c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-p.

42 CFR 483.10

(c)(2) Payments for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

TN No. 93-60  
Supersedes TN No. 91-75 Approval Date JAN 19 1994 Effective Date OCT 1 - 1993

Revision: ~~EPA-AT-90-32 (EPP)~~  
May 22, 1980

State New York

Citation  
42 CFR 440.260  
AT-78-90

3.1(d) Methods and Standards to Assure  
Quality of Services

The standards established and the  
methods used to assure high quality  
care are described in ATTACHMENT 3.1-C.

NY # 77-23  
Supersedes  
NY # 74-38

Approval Date 12/28/77 Effective Date 7/1/77

Revision: ~~NY-AT-80-28 (EPP)~~  
May 22, 1980

State                      New York

Citation  
42 CFR 441.20  
AT-78-90

3.1(e) Family Planning Services

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

TN # 77-23  
Supersedes  
TN # 74-38

Approval Date 12/28/77 Effective Date 7/1/77

Revision: HCFA-PM-87-5 (BERC)  
APRIL 1987

OMB No.: 0938-0193

State/Territory: New York

Citation  
42 CFR 441.30  
AT-78-90

3.1 (f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

Yes.

No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)  
of the Act,  
P.L. 99-272  
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

No.

Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

TN No. 87-47  
Supersedes  
TN No. 77-23

Approval Date NOV 21 1991

Effective Date 11/1987

HCFA ID: 1008P/0011P

Revision: HCFA-FR-87-4 (BERC)  
MARCH 1987

OMB No.: 0938-0191

State/Territory: New York

Citation  
42 CFR 431.110(b)  
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of  
the Act,  
P.L. 99-509  
(Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

- (1) Are medically dependent on a ventilator for life support at least six hours per day;
- (2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--
  - 30 consecutive days;
  - \_\_\_ days (the maximum number of inpatient days allowed under the State plan);
- (3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;
- (4) Have adequate social support services to be cared for at home; and
- (5) Wish to be cared for at home.

Yes. The requirements of section 1902(e)(9) of the Act are met.

Not applicable. These services are not included in the plan.

TN No. 87-47  
Supersedes  
TN No. 79-4

Approval Date NOV 21 1991

Effective Date \_\_\_\_\_

OFFICIAL

Revision: HCFA-PM-93-5 (MB)  
May 1993

State: New York

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

(i) Qualified Medicare Beneficiary (QMB)

1902 (a) (10) (E) (i) and  
1905 (p) (1) of the Act

The Medicaid agency pays Medicare Part A premiums (If applicable) and Part B premiums for Individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-In agreement for such payment as indicated below.

Buy-in agreement for:

X Part A X Part B

       The Medicaid agency pays premiums for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

TN No. 04-000  
Supersedes 93-27 Approval Date APR 15 2004 Effective Date APR 01 2004  
TN No. 91-75

Revisior: ADFA-PH-97-3 (0110)  
~~December~~ 1997

State: New York

Citation

1902(a)(10)(E)(ii)  
and 1905(s) of the Act

(ii) Qualified Disabled and Working Individual (QDWI)

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iii)  
and 1905(p)(3)(A)(ii)  
of the Act

(iii) Specified Low-Income Medicare Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the

SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iv)(I),  
1905(p)(3)(A)(ii), and  
1933 of the Act

(iv) Qualifying Individual-1 (QI-1)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.

1902(a)(10)(E)(iv)(II),  
1905(p)(3)(A)(ii), and  
1933 of the Act

(v) Qualifying Individual-2 (QI-2)

The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10)(E)(iv)(II) and subject to 1933 of the Act.

Revises: RCF-PA-97-1 (020)  
~~December~~ 1997

State: New York

Citation

1843(b) and 1905(a)  
of the Act and  
42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

- All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d)(2).
- Individuals receiving title II or Railroad Retirement benefits.
- Medically needy individuals (FFP is not available for this group).

1902(a)(30) and (2)  
1905(a) of the Act

- Other Health Insurance  
The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

State: New York

Citation

1902(a)(30), 1902(n),  
1905(a), and 1916 of the Act

Sections 1902  
(a)(10)(E)(i) and  
1905(p)(3) of the Act

1902(a)(10), 1902(a)(30),  
and 1905(a) of the Act

42 CFR 431.625

1902(a)(10), 1902(a)(30),  
1905(a), and 1905(p)  
of the Act

(b) Deductibles, Coinsurance

(1) Medicare Part A and B

Supplement 1 to ATTACHMENT 4.19-3 describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

(i) Qualified Medicare Beneficiaries (QMBs)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

— For the entire range of services available under Medicare Part B.

X Only for the amount, duration, and scope of services otherwise available under this plan.

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

93-27

TN No.

Supersedes

TN No.

91-75

Approval Date

SEP 14 1993

Effective Date

APR 1 1993

Revision: HCFA-PM-91-8 (MB)  
October 1991

OMB No.:

State/Territory: New York

Citation

Condition or Requirement

1906 of the Act

(c) Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations

The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.

When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).

1902(a)(10)(F) of the Act

(d)  The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.

TN No. 91-54

Supercedes

TN No. **New**

Approval Date

JUL 27 1995

Effective Date JUL 1 - 1991

HCFA ID: 7983E

Revision: ~~HFA-AT-80-29~~ (APP)  
May 22, 1980

State New York

Citation  
42 CFR 441.101,  
42 CFR 431.620 (c)  
and (d)  
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in  
Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620 (c) and (d) are met.

Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

IN # 75-11  
Supersedes  
IN # 74-2

Approval Date 7/17/75 Effective Date 7/1/75

Revision: ESPA-AT-80-38 (EPP)  
May 22, 1980

State New York

Citation  
42 CFR 441.252  
AT-78-99

3.4 Special Requirements Applicable to Sterilization Procedures

All requirements of 42 CFR Part 441, Subpart F are met.

IN # 79-5  
Supersedes  
IN # 77-23

Approval Date 5/4/79

Effective Date 1/1/79

Revision: HCFA-PM-91- - (BPD)  
AUGUST 1991

OMB No.: 0938-

State: New York

Citation  
1902(a), 521  
and 1925 of  
the Act

3.5

Families Receiving Extended Medicaid Benefits

- (a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).
- (b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Medical or remedial care provided by licensed practitioners.

Home health services.

91-75  
 TN No. 87-47 Supersedes Approval Date MAY 3 1992 Effective Date OCT 1 1991  
 TN No. 87-47

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938-

State: New York

Citation 3.5 Families Receiving Extended Medicaid Benefits  
(Continued)

- Private duty nursing services.
- Physical therapy and related services.
- Other diagnostic, screening, preventive, and rehabilitation services.
- Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- Intermediate care facility services for the mentally retarded.
- Inpatient psychiatric services for individuals under age 21.
- Hospice services.
- Respiratory care services.
- Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

TN No. 91-75

Supersedes

TN No. 90-3

Approval Date

MAR 3 1991

Effective Date

OCT 1 1991

HCFA ID: 7982E

Revision: HCFA-PM-91- - (BPD)  
AUGUST 1991

OMB No.: 0938-

State: New York

Citation

3.5 Families Receiving Extended Medicaid Benefits  
(Continued)

(c)  The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

1st 6 months       2nd 6 months

The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

1st 6 mos.       2nd 6 mos.

(d)  (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

Enrollment in the family option of an employer's health plan.

Enrollment in the family option of a State employee health plan.

Enrollment in the State health plan for the uninsured.

Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

91-75  
TN No. 91-75 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
Supersedes 90-27  
TN No. 90-27

HCFA ID: 7982E

Revision: HCFA-91-4 (BPD)  
August 1991

31d

OMB No.: 0938-

State: New York

Citation 3.5 Families Receiving Extended Medicaid Benefits  
(Continued)

Supplement 2 to Attachment 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency -

(i) Pays all premiums and enrollments fees imposed on the family for such plan(s)

(ii) Pays all deductibles and coinsurance imposed on the family for such plan(s)

3.6 Unemployed Parent

For purposes of determining whether a child is deprived on the basis of the unemployment of a parent, the agency -

Uses the standard for measuring unemployment which was in the AFDC State Plan in effect on July 16, 1996.

Uses the following more liberal standard to measure unemployment:

An individual will be considered unemployed if the family's countable income and resources as determined for the group defined in Section 1931 are below the eligibility standard used for that group (Attachment 2.6-A, Supplement 12 and Supplement 1 to Attachment 2.6-A, Item A-1) or if the family's income and resources, minus deductions allowed for medically needy, including incurred medical expenses, is less than the medically needy income level (Supplement 1 to Attachment 2.6-A, Item D) and resource level (Supplement 2 to Attachment 2.6-A, Item B).

(Note: This effectively eliminates the old AFDC deprivation requirements from all groups.)

TN 99-41 Approval Date MAR 31 2000

Supersedes TN 91-75 Effective Date OCT 1 1999

- Enrollment in an eligible health maintenance organization (HMO) that has an enrollment of less than 50 percent of Medicaid recipients who are not recipients of extended Medicaid.\*

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

- (i) Pays all premiums and enrollment fees imposed on the family for such plan(s).
- (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

\*only if previously enrolled

TN 90-27 Approval Date JUL 20 1990

Supersedes TN NEW Effective Date APR 01 1990

Revision: HCFA-PM-87-4

OMB No.: 0938-0193

State/Territory: NEW YORK STATE

**SECTION 4 - GENERAL PROGRAM ADMINISTRATION**

Citation

42 CFR 431.15  
AT-79-29

**4.1 Methods of Administration**

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

42 USC 1396a(13)(A)

The State provides for a public process that conforms to the requirements of section 4711 of the federal Balanced Budget Act of 1997 for determination of rates of payment under this Plan for Attachments 4.19-A Parts 1, 2, 3, 4, 5, 7 and Attachment 4.19-D Parts 1 and 2.

TN NO.

97-37

APPROVAL DATE

FEB 9 1998

EFFECTIVE DATE

EST 1 1997

SUPERSEDES

TN NO.

87-47

Revision: ~~AT-80-33~~ (Rev.)  
May 22, 1980

State New York

Citation  
42 CFR 431.202  
AT-79-29  
AT-80-34

4.2 Hearings for Applicants and Residents

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

NY § 74-16  
Supersedes  
NY § 74-2

Approval Date 4/3/75

Effective Date 4/1/74

State: New York

Citation

Services During Appeal

P.L. 101-508

Section 4724

The State shall continue to provide medical assistance until a final determination of disability or blindness is made by SSA in those cases where a state determination of disability or blindness, made in accordance with section 1614(a) of the Social Security Act, was reversed by a subsequent SSA decision.

YES

NO

TN NO. 91-30

APPROVAL DATE JUL 22 1991

SUPERSEDES TN NO. new

EFFECTIVE DATE APR 1 1991

State/Territory: New York

Citation  
42 CFR 431.301  
AT-79-29

4.3 Safeguarding Information on Applicants and Recipients

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

52 FR 5967

All other requirements of 42 CFR Part 431, Subpart F are met.

TR No. 87-49  
Supersedes  
TR No. 74-2

Approval Date JUN 4 1991

Effective Date OCT - 1 1987

HCFA ID: 1010P/0012P

Revision: HCFA-PH-87-4 (BERC)  
MARCH 1987

OMB No.: 0938-0193

State/Territory: New York

Citation  
42 CFR 431.800(c)  
50 FR 21839  
1903(u)(1)(D) of  
the Act,  
P.L. 99-509  
(Section 9407)

4.4 Medicaid Quality Control

- (a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.
- (b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

Yes.

Not applicable. The State has an approved Medicaid Management Information System (MMIS).

TN No. 87-47  
Supersedes  
TN No. 85-21

Approval Date NOV 21 1991

Effective Date \_\_\_\_\_

Revision: HCFA-PH-88-10 (BERC)  
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: NEW YORK

Citation  
42 CFR 455.12  
AT-78-90  
48 FR 3742  
52 FR 48817

4.5 Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

TM No. 89-43  
Supersedes  
TM No. 83-34

Approval Date MAR 13 1989

Effective Date JUL 1 1989

HCFA ID: 1010P/0012P

New: HCFA-PM-99-3 (CMSO)  
JUNE 1999

State: NEW YORK

Citation  
Section 1902(a)(64) of  
the Social Security Act  
P.L. 105-33

4.5a Medicaid Agency Fraud Detection and Investigation  
Program

The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

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TN No. **99-30** Approval Date DEC 6 1999 Effective Date JUL 1 1999  
Supersedes -                       
TN No.                     

**New**

Revisior: ~~HTA-AT-80-38 (APP)~~  
May 22, 1980

State New York

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Citation  
42 CFR 431.16  
AT-75-29

#### 4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

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IN # 76-54  
Supersedes  
IN # 75-38

Approval Date 1/28/77 Effective Date 10/1/76

Revision: ~~WPA-AT-80-38~~ (BPP)  
May 22, 1980

State New York

Citation  
42 CFR 431.17  
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

TV # 74-2  
Supersedes  
TV # None

Approval Date 12/31/74

Effective Date Prior to 1/1/74

Revision: ~~ETA-AT-80-38~~ (277)  
May 22, 1980

State            New York

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Citation  
42 CFR 431.18 (b)  
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

IN # 74-2  
Supersedes  
IN # None

Approval Date 12/31/74

Prior To  
Effective Date 1/1/74

Revision: ~~EN-AT-90-33 (377)~~  
 May 22, 1980

State New York

Citation  
 42 CFR 433.37  
 AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

EN # 74-2

Supersedes

EN # None

Approval Date 12/31/74

Effective Date 1/1/74 <sup>Printed</sup>

Revision: HCFA-PM-99-3 (CMSO)  
JUNE 1999

State: NEW YORK

Citation  
42 CFR 431.51  
AT-78-90  
46 FR 48524  
48 FR 23212  
1902 (a) (23)  
of the Act  
P.L. 100-93  
(section 8(f))  
P.L. 100-203  
(Section 4113)

4.10 Free Choice of Providers

Section 1902(a)(23)  
of the Social Security Act  
P.L. 105-33

- (a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.
- (b) Paragraph (a) does not apply to services furnished to an individual--
- (1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or
  - (2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or
  - (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, or
  - (4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services.
- (c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

TN No. 99-30 DEC 6 1999  
Supersedes Approval Date \_\_\_\_\_ Effective Date JUL 1 1999  
TN No. 92-04

State New York

4.11 Relations with Standard Setting and Survey agencies

Citation

42 CFR 431.610

AT-79-90

AT-80-34

- (a) The State Agency utilized by the Secretary to determine qualifications of institutions and supplies of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provides services to Medicaid recipients. This agency is : The New York State Department of Health.
- (b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are) : The New York State Department of Health and The Office of Mental Health
- (c) Attachment 4.11-A describes the standards specified in paragraphs (a) and (b) above, are kept on file and made available to the Health Care Financing Administration, on request.

TR No. 97-10  
Supersedes 86-7  
TR No. \_\_\_\_\_

Approval Date: JUL 08 1997

Effective Date: OCT 01 1996

Revision: ~~SCA-AT-90-38 (SFP)~~  
May 22, 1980

State New York

Citation  
42 CFR 431.610  
AT-78-90  
AT-89-34

4.11 (d) The New York State Department

of Health (agency)  
which is the State agency responsible  
for licensing health institutions,  
determines if institutions and  
agencies meet the requirements for  
participation in the Medicaid  
program. The requirements in 42 CFR  
431.610(e), (f) and (g) are met.

NY # 74-14  
Supersedes  
NY # 74-2

Approval Date 4/12/76

Effective Date 4/1/76

Revision: ~~ECR-AT-80-33 (APP)~~  
May 22, 1980

State New York

Citation  
42 CFR 431.105 (b)  
AT-78-90

4.12 Consultation to Medical Facilities

- (a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105 (b).
- (b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105 (b).

Yes, as listed below:

1. Public Home infirmaries.
2. Infirmary section of a private home for aged.
3. Institutions for mental diseases including sections for mental diseases of general hospitals.
4. Institutions for Tuberculosis including sections for Tuberculosis of general hospitals.
5. Medical rehabilitation centers.
6. Such other facilities authorized by State law in which care or treatment may be provided.

Not applicable. Similar services are not provided to other types of medical facilities.

TN # 74-2  
Supersedes  
TN # None

Approval Date 12/31/74

Effective Date 1/1/74 <sup>Prior to</sup>

Revision: HCFA-PM-91- - (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

- 42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
  - 42 CFR Part 483 1919 of the Act (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
  - 42 CFR Part 483, Subpart D (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.
  - 1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.
- Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

91-75  
 TN No. 87-47 Approval Date 4/20/91 Effective Date OCT 1 1991  
 Supersedes

HCFA ID: 7982E

Revision: HCFA-PM-91-9  
October 1991

(MB)

OMB No.:

State/Territory: New York

Citation

1902(a)(58)

1902(w) 4.13

(e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

- (1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:
  - (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
  - (b) Provide written information to all adult individuals on their policies concerning implementation of such rights;
  - (c) Document in the individual's medical records whether or not the individual has executed an advance directive;
  - (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
  - (e) Ensure compliance with requirements of State Law (whether

TN No. 91-81  
Supersedes            Approval Date JAN 15 1992 Effective Date DEC 01 1991  
TN No. —New

HCFA ID: 7982E

45(b)

Revision: HCFA-PM-91-9  
October 1991

(MB)

OMB No.:

State/Territory: New York

statutory or recognized by the courts) concerning advance directives; and

- (f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.
- (2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:
- (a) Hospitals at the time an individual is admitted as an inpatient.
  - (b) Nursing facilities when the individual is admitted as a resident.
  - (c) Providers of home health care or personal care services before the individual comes under the care of the provider;
  - (d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and
  - (e) Health maintenance organizations at the time of enrollment of the individual with the organization.
- (3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

\_\_\_\_ Not applicable. No State law or court decision exist regarding advance directives.

TN No. 91-91  
Supersedes \_\_\_\_\_ Approval Date JAN 15 1992 Effective Date DEC 01 1991  
TN No. **New** HCFA ID: 7982E

Revision: HCFA-PM- 91-10 (MB)  
DECEMBER 1991

State/Territory: New York

Citation

42 CFR 431.60  
42 CFR 456.2  
50 FR 15312  
1902(a)(30)(C) and  
1902(d) of the  
Act, P.L. 99-509  
(Section 9431)

4.14 Utilization/Quality Control

- (a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

X Directly

X By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO--

- (1) Meets the requirements of §434.6(a);
- (2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
- (3) Identifies the services and providers subject to PRO review;
- (4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and
- (5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

X Quality review requirements described in section 1902(a)(30)(C) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the PRO designed under 42 CFR Part 462.

— By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

1902(a)(30)(C)  
and 1902(d) of the  
Act, P.L. 99-509  
(section 9431)

TN No. 92-09

Supersedes

TN No. 89-43

Approval Date

APR 30 1992

Effective Date JAN 1 1992

Revision: HCFA-PH-85-3 (BERC)  
MAY 1985

State: NEW YORK

OMB NO. 0938-0193

Citation  
42 CFR 456.2  
50 FR 15312

- 4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

All hospitals (other than mental hospitals).

Those specified in the waiver.

No waivers have been granted.

N No. 85-32  
Supersedes  
TN No. 76-23

Approval Date MAR. 6 1985

Effective Date OCT. 1 1985

HCFA ID: 0048P/0002P

Revision: HCFA-PH-85-7 (BERC)  
JULY 1985

OMB NO.: 0938-0193

State/Territory: NEW YORK

Citation  
42 CFR 456.2  
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

All mental hospitals.

Those specified in the waiver.

No waivers have been granted.

Not applicable. Inpatient services in mental hospitals are not provided under this plan.

TR No. 85-32  
Supersedes  
TR No. 76-23

Approval Date MAR. 6 1986

Effective Date OCT. 1 1985

Revision: HCFA-PM-85-3 (BERC)  
MAY 1985

State: NEW YORK

OMB NO. 0938-0193

Citation  
42 CFR 456.2  
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

All skilled nursing facilities.

Those specified in the waiver.

No waivers have been granted.

TM No. 85-32  
supersedes  
TM No. 76-23

Approval Date MAR. 6 1986

Effective Date OCT. 1 1985

HCFA ID: 0048P/0002P

Revision: HCFA-PH-85-3 (BERC)  
MAY 1985

State: NEW YORK

OMB NO. 0938-0193

Citation  
42 CFR 456.2  
50 FR 15312

4.14  (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

- Facility-based review.
- Direct review by personnel of the medical assistance unit of the State agency.
- Personnel under contract to the medical assistance unit of the State agency.
- Utilization and Quality Control Peer Review Organizations.
- Another method as described in ATTACHMENT 4.14-A.
- \*  Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.
- Not applicable. Intermediate care facility services are not provided under this plan.

\* See approval letter

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No. 85-32  
 supersedes  
 TM No. 76-23

Approval Date MAR. 6 1986      Effective Date OCT. 1 1985

Revision: HCFA-PM-91-10 (MB)  
DECEMBER 1991

State/Territory: New York

Citation

1902(a)(30)  
and 1902(d) of  
the Act,  
P.L. 99-509  
(Section 9431)  
P.L. 99-203  
(section 4113)

4.14 Utilization/Quality Control (Continued)

(f) The Medicaid agency meets the requirements of section 1902(a)(30) of section 1902(a)(30) of the Act for control of the assurance of quality furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

- A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.
- A private accreditation body.
- An entity that meets the requirements of the Act, as determined by the Secretary.

The Medicaid agency certifies that the entity in the preceding subcategory under 4.14(f) is not an agency of the State.

92-09

TN No.             
Supersedes  
TN No. 87-47

Approval Date APR 30 1992 Effective Date JAN 1 1992

Revision: HCFA-PM-92-2 (HSQS)  
MARCH 1992

State/Territory: New York

Citation 4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part  
456 Subpart  
I, and  
1902(a)(31)  
and 1903(g)  
of the Act

— The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

— ICFs/MR;

— Inpatient psychiatric facilities for recipients under age 21; and

— Mental Hospitals.

42 CFR Part  
456 Subpart  
A and  
1902(a)(30)  
of the Act

X All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

— Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

— Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

— Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

TN No. 92-23  
Supersedes  
TN No. 76-27

Approval Date JUL 30 1992

Effective Date APR 1 1992

HCFA ID: \_\_\_\_\_

90-25

Revision: HCFA-AT-80-38 (EPP)  
May 22, 1980

State

New York

Citation  
42 CFR 431.615(c)  
AT-78-90

4.16 Relations with State Health and Vocational  
Rehabilitation Agencies and Title V  
Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

The Medicaid agency will provide for coordination of the operations under Title XIX with the State's operations under the special supplemental food program for women, infants and children (WIC) under Section 17 of the Child Nutrition Act of 1966 as specified by amendment to Section 1902 (a) (11) of the Social Security Act.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

JUL 20 1990

90-25

Superseded by 74-2

Revision: HCFA-PM-95-3 (MB)  
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

Citation  
42 CFR 433.36(c)  
1902(a)(18) and  
1917(a) and (b) of  
the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

X The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

X The State imposes liens on real property on account of benefits incorrectly paid.

X The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

X The State imposes liens on both real and personal property of an individual after the individual's death.

TN No. 95-28

Supersedes

TN No.

Approval Date SEP 27 1998

Effective Date APR 01 1995

**New**

Revision: HCFA-PM-95-3 (MB)  
May 1995

**OFFICIAL**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State/Territory: New York

(b) Adjustments or Recoveries

The State complies with the requirement of section 1917 (b) of the Act and regulations at 42 CFR 433.36 (h) - (i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2)  The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917 (a) (1) (B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:  
Payment for all services are recovered for individuals age 55 and over, except for Medicare cost sharing as specified in section 4.17 (b) (3) - continued).

**OFFICIAL**

Revision: HCFA-PM-95-3 (MB)  
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:           New York          

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

TN No.: 10-14  
Supersedes  
TN No.: New

Approval Date: SEP 22 2010 Effective Date: April 1, 2010

**OFFICIAL**Revision: HCFA-PM-95-3 (MB)  
MAY 1995

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

- (4)  The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, supplement 8b.

The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

- The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

TN No. 04-39Approval Date MAR 23 2015Supersedes 95-28  
TN No. 95-28DEC 31 2004

Effective Date \_\_\_\_\_

*New*

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

- (1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.
- (2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:
  - (a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or
  - (b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.
- (3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

TN No. 95-28

Supersedes

Approval Date

SEP 27 1995

Effective Date

APR 01 1995

TN No.

New

Revision: HCFA-FM-95-3 (MB)  
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

(d) ATTACHMENT 4.17-A

- (1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).
- (2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).
- (3) Defines the following terms:
  - o estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
  - o individual's home,
  - o equity interest in the home,
  - o residing in the home for at least 1 or 2 years,
  - o on a continuous basis,
  - o discharge from the medical institution and return home, and
  - o lawfully residing.

TN No. 95-28 Approval Date SEP 27 1998 Effective Date APR 01 1995  
Supersedes  
TN No. New

Revision: HCFA-PM-95-3 (MB)  
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

- (4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.
- (5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.
- (6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

TN No. 95-28 Approval Date SEP 27 1998 Effective Date APR 01 1995  
 Supersedes  
 TN No. New

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

CMS No.: 0936-

State/Territory: New York

Citation  
42 CFR 447.51  
through 447.53

4.16 Recipient Cost Sharing and Similar Charges

1916(a) and (b)  
of the Act

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

(b) Except as specified in items 4.16(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as Qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

- (1) No enrollment fee, premium, or similar charge is imposed under the plan.
- (2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

Age 19

Age 20

Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

TN 92-28 Approval Date JAN 25 1994

Supersedes TN 91-75 Effective Date NOV 1 - 1993

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation: 4.18(b)(2) (Continued)

42 CFR 447.51  
through  
447.5E

(iii) All services furnished to pregnant women.

Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a health maintenance organization in which the individual is enrolled.

1916 of the Act,  
P.L. 99-272,  
(Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

TN 92-28 \* Approval Date JAN 25 1994

Supersedes TN 91-75 Effective Date NOV 1 - 1993

Revision: HCFA-PM-91- - (SFO)  
AUGUST 1991

CMS No.: C93E-

State/Territory: New York

Citation 4.18(b) (Continued)

42 CFR 447.51  
through  
447.46

(3) Unless a waiver under 42 CFR 431.55(c) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

Not applicable. No such charges are imposed.

(4) For any service, no more than one type of charge is imposed.

(5) Charges apply to services furnished to the following age groups:

18 or older

19 or older

20 or older

21 or older

Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

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TN 92-28 Approval Date JAN 25 1994  
Supersedes TN 91-75 Effective Date NOV 1 - 1993

Revision: HCFA-PM-91-1 (SPD)  
AUGUST 1991

OMS No.: 0938-

State/Territory: New York

Citation: 4.18(b)(3) (Continued)

42 CFR 447.51  
through 447.58

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

- (A) Service(s) for which a charge(s) is applied;
- (B) Nature of the charge imposed on each service;
- (C) Amount(s) of and basis for determining the charge(s);
- (D) Method used to collect the charge(s);
- (E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;
- (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
- (G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

Not applicable. There is no maximum.

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TN 92-28 Approval Date JAN 25 1994  
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Revision: HCFA-PM-91- (BFD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation

- 1916(c) of the Act 4.18(b)(4)  A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(i)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
- 1902(a)(52) and 1925(b) of the Act 4.18(b)(5)  For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
- 1916(d) of the Act 4.18(b)(6)  A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

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AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation 4.18(c)  Individuals are covered as medically needy under the plan.

42 CFR 447.51  
through 447.58

- (1)  An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through  
447.58

- (2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

- (i) Services to individuals under age 18, or under--

Age 19

Age 20

Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

TN No. 92-28

Supersedes

TN No. 91-75

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HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation 4.18 (c)(2). (Continued)

42 CFR 447.51  
through  
447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act,  
P.L. 99-272  
(Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through  
447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

Not applicable. No such charges are imposed.

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TN No. 91-75

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HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation 4.18(c)(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

18 or older

19 or older

20 or older

21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

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Supersedes TN No. 91-75

HCFA ID: 7982E

Revision: HCFA-PM-91- (SFD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation: 4.18(c)(2) (Continued)

447.51 through

447.52

For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

- (A) Service(s) for which charge(s) is applied;
- (B) Nature of the charge imposed on each service;
- (C) Amount(s) of and basis for determining the charge(s);
- (D) Method used to collect the charge(s);
- (E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;
- (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
- (G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

Not applicable. There is no maximum.

TN 92 - 28

Approval Date JAN 25 1994

Supersedes TN 91-75

Effective Date NOV 1 - 1993

Revision: HCFA-PM-91- - (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation 4.19 Payment for Services

42 CFR 447.252  
1902(a)(13)  
and 1923 of  
the Act

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

Inappropriate level of care days are not covered.

91-75  
TN No. 91-75  
Supersedes TN No. 87-47 Approval Date MAR 3 1992 Effective Date OCT 1 1991

HCFA ID: 7982E

Revision: HCFA-PM-93-6 (MB)  
August 1993

OMB No.: 0938-

State/Territory: New York

Citation  
42 CFR 447.201  
42 CFR 447.302  
52 FR 28648  
1902(a)(13)(E)  
1903(a)(1) and  
(n), 1920, and  
1926 of the Act

4.19(b) In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:

- (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
- (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

1902(a)(10) and  
1902(a)(30) of  
the Act

SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

No. **93-48**

Supersedes

TN No. 91-75

Approval Date DEC 10 1993

Effective Date JUL 1 - 1993

Revision: ~~AT-AC-60-28 (227)~~  
May 22, 1980

State New York

Citation  
42 CFR 447.40  
AT-78-90

4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

Yes. The State's policy is described in ATTACHMENT 4.19-C.

No.

IN # 78-23  
Supersedes  
IN # 77-8

Approval Date 9/29/78 Effective Date 9/1/78

State/Territory: New YorkCitation42 CFR 447.252  
47 FR 47964  
48 FR 56046  
42 CFR 447.280  
47 FR 31518  
52 FR 28141

4.19 (d)

37 49

- (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

- (2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

- (3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

- (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

TN No. 87-49  
Supersedes  
TN No. 84-2

Approval Date JUN - 4 1991

Effective Date OCT ' 1 1987

HCFA ID: 1010P/0012P

State NEW YORK

Citation  
42 C.R. 447.45 (c)  
AT-79-50

4.19 (e) The Medicaid agency meets all requirements of 42 C.R. 447.45 for timely payment of claims.

ATTACHMENT 4.19-2 specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

Di #: 81-17  
Supervisor  
Di #: NA

Approval Date 18 MAR 1983

Effective Date 10/1/81

Page submitted 3/6/82

Revision: HCFA-PH-87-4 (BERC)  
MARCH 1987

OMB No.: 0938-0193

State/Territory: New York

Citation

42 CFR 447.15  
AT-78-90  
AT-80-34  
48 FR 5730

4.19 (f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

TR No. 87-47  
Supersedes  
TR No. 83-16

Approval Date NOV 21 1991 Effective Date \_\_\_\_\_

Revision: ~~AT-80-33 (EPP)~~  
May 22, 1980

State New York

Citation  
42 CFR 447.201  
42 CFR 447.202  
AT-78-90

4.19 (g) The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

IN § 79-24  
Supersedes  
IN § 78-19

Approval Date 10/16/79

Effective Date 8/6/79

Revision: HCFA-AT-90-60 (BPP)  
August 12, 1980

State New York

Citation

42 CFR 447.201  
42 CFR 447.203  
AT-78-90

4.19 (b) The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

IN # 79-24  
Supersedes  
IN # 78-12

Approval Date 10/16/79 Effective Date 8/6/79



Revision: HCFA-PM-91- - (BPD)  
AUGUST 1991

OMB No.: 0938-

State: New York

Citation

42 CFR 447.201 and 447.205 4.19(j) The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.

1903(v) of the Act (k) The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

91-75  
TN No. 87-49 Supersedes Approval Date MAR 3 1992 Effective Date OCT 1 1991

HCFA ID: 7982E

Revision: HCFA-PM-92-7 (MB)  
October 1992

State/Territory: New York

Citation

1903(i)(14)  
of the Act

4.19(1) The Medicaid agency meets the requirements of section 1903(i)(14) of the Act\* with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

\* and Section 6400 of the State Medicaid Manual

TN No. ~~92-71~~ Approval Date MAR 23 1993 Effective Date OCT 1- 1992  
Supersedes  
TN No. **New**

Revision: HCFA-PM-94-8 (MB)  
OCTOBER 1994

State/Territory: New York

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Citation

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4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2) (i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in (C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

Y sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

— is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

— sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

— is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine:

1926 of (iii) Medicaid beneficiary access to immunizations is the Act assured through the following methodology:

If indicated, the State will show, via the obstetrical/pediatric State Plan amendment submittal, that the VFC administration fee meets the applicable statutory requirements of the Social Security Act.

TN No. 94-47

Supersedes

TN No.

**New**

Approval Date JAN 30 1995

Effective Date OCT 1 - 1994

Revision: ~~AT-78-90-39~~ (257)  
May 22, 1980

State New York

Citation  
42 CFR 447.25 (b)  
AT-78-90

4.20 Direct Payments to Certain Recipients for  
Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

- Yes, for  physicians' services
- dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

- Not applicable. No direct payments are made to recipients.

IN # 74-25  
Supersedes  
IN # 74-14

Approval Date 4/21/75

Effective Date 1/1/74

Revision: HCFA-AT-81-34 (BPP)

81 39

10-81

State

NEW YORK

Citation

4.21 Prohibition Against Reassignment of  
Provider Claims

42 CFR 447.10(e)  
AT-78-90  
46 FR 42699

Payment for Medicaid services  
furnished by any provider under this  
plan is made only in accordance with  
the requirements of 42 CFR 447.10.

TN # 81-33

Supersedes

TN # 78-19

Approval Date 05/27/82

Effective Date 01/01/82

Revision: HCFA-PM-94-1 (MB)  
FEBRUARY 1994

State/Territory: New York

Citation

4.22 Third Party Liability

- 42 CFR 433.137 (a) The Medicaid agency meets all requirements of:
- (1) 42 CFR 433.138 and 433.139.
  - (2) 42 CFR 433.145 through 433.148.
  - (3) 42 CFR 433.151 through 433.154.
  - (4) Sections 1902(a)(25)(H) and (I) of the Act.
- of the Act
- 42 CFR 433.138(f) (b) ATTACHMENT 4.22-A --
- (1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;
  - (2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);
  - (3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and
  - (4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.
- 42 CFR 433.138(g)(1)(ii) and (2)(ii)
- 42 CFR 433.138(g)(3)(i) and (iii)
- 42 CFR 433.138(g)(4)(i) through (iii)

94-12

TN No. 87-49 Approval Date MAY 9 - 1994 Effective Date JAN 1 - 1994  
Supersedes  
TN No. 87-49

Revision: HCFA-PM-94-1 (MB)  
FEBRUARY 1994

State/Territory: New York

Citation

- 42 CFR 433.139(b)(3) X (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
- (ii)(A)
- (d) ATTACHMENT 4.22-B specifies the following:
- 42 CFR 433.139(b)(3)(ii)(C) (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).
- 42 CFR 433.139(f)(2) (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
- 42 CFR 433.139(f)(3) (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
- 42 CFR 447.20 (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

94-12

TN No. \_\_\_\_\_ Approval Date MAY 9 - 1994 Effective Date JAN 1 - 1994  
Supersedes \_\_\_\_\_  
TN No. 87-49

Revision: HCFA-PM-94-1 (MB)  
FEBRUARY 1994

State/Territory: New York

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

Other appropriate State agency(s)--  
\_\_\_\_\_  
\_\_\_\_\_

Other appropriate agency(s) of another State--  
\_\_\_\_\_  
\_\_\_\_\_

Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

The Secretary's method as provided in the State Medicaid Manual, Section 3910.

The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

94-12

TN No. \_\_\_\_\_ Approval Date MAY 9 - 1994 Effective Date JAN 1 - 1994  
Supersedes \_\_\_\_\_  
TN No. 86-9

Revision: HCFA-AT-84-2 (BERC)  
01-84

State NEW YORK

Citation  
42 CFR Part 434.4  
48 FR 54013

4.23 Use of Contracts

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

Not applicable. The State has no such contracts.

TN # 84-3  
Supersedes  
TN # 78-26

Approval Date 4 MAY 1984 Effective Date 01 APR 1984

Revision: HCFA-PM-94-2 (BPD)  
APRIL 1994

NEW YORK

State/Territory:

Citation  
42 CFR 442.10  
and 442.100  
AT-78-90  
AT-79-18  
AT-80-25  
AT-80-34  
52 FR 32544  
P.L 100-203  
(Sec. 4211)  
54 FR 5316  
56 FR 48826

4.24

Standards for Payments for Nursing Facility  
and Intermediate Care Facility for the Mentally  
Retarded Services

With respect to nursing facilities and  
intermediate care facilities for the mentally  
retarded, all applicable requirements of  
42 CFR Part 442, Subparts B and C are met.

Not applicable to intermediate care  
facilities for the mentally retarded;  
such services are not provided under this  
plan.

94-32

TN No.

Supersedes

TN No.

80-4

Approval Date

SEP 8 1994

Effective Date

APR 1 - 1994



Revision: HCFA-PM- (MB)

State/Territory: New YorkCitation1927(g)  
42 CFR 456.700

## 4.26 Drug Utilization Review Program

1927(g)(1)(A)

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

2. The DUR program assures that prescriptions for outpatient drugs are:

- Appropriate
- Medically necessary
- Are not likely to result in adverse medical results

1927(g)(1)(a)  
42 CFR 456.705(b) and  
456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

1927(g)(1)(B)  
42 CFR 456.703  
(d) and (f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia-Drug Information
- American Medical Association Drug Evaluations

**93-21**

TN No.

Supersedes

TN No.

Approval Date SEP 13 1993

Effective Date

APR 1 - 199392-23

State/Territory: New York

Citation

1927(g)(1)(D)  
42 CFR 456.703(b)

D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

- Prospective DUR
- Retrospective DUR. \*

1927(g)(2)(A)  
42 CFR 456.705(b)

E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927(g)(2)(A)(i)  
42 CFR 456.705(b),  
(1)-(7))

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Drug-interactions with non-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse/misuse

1927(g)(2)(A)(ii)  
42 CFR 456.705 (c)  
and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B)  
42 CFR 456.709(a)

F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

\* The State's RetroDUR System will capture and perform retrospective DUR on any drug product not included in a nursing home's per diem rate.

93-21

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TN No. \_\_\_\_\_ Approval Date SEP 18 1993 Effective Date APR 1- 1993  
 Supersedes \_\_\_\_\_  
 TN No. 92-23

State/Territory: New YorkCitation927(g)(2)(C)  
42 CFR 456.709(b)

- F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage/duration of drug treatment
- Clinical abuse/misuse

1927(g)(2)(D)  
42 CFR 456.711

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

1927(g)(3)(A)  
42 CFR 456.716(a)

- G.1. The DUR program has established a State DUR Board either:

Directly, or  
 Under contract with a private organization

1927(g)(3)(B)  
42 CFR 456.716  
(A) AND (B)

2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs.
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- Medical quality assurance.

927(g)(3)(C)  
42 CFR 456.716(d)

3. The activities of the DUR Board include:

- Retrospective DUR,
- Application of Standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

TN No. 93-21 Approval Date SEP 13 1993 Effective Date APR 1- 1993  
 Supersedes 92-23  
 TN No. 92-23

Revision: HCFA-PM-

(MB)

OMB No.

State/Territory: New YorkCitation

1927(g)(3)(C)  
42 CFR 456.711  
(a)-(d)

G.4 The interventions include in appropriate instances:

- Information dissemination
- Written, oral, and electronic reminders
- Face-to-Face discussions
- Intensified monitoring/review of prescribers/dispensers

1927(g)(3)(D)  
42 CFR 456.712  
(A) and (B)

H. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.

1927(h)(1)  
42 CFR 456.722

I.1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:

- real time eligibility verification
- claims data capture
- adjudication of claims
- assistance to pharmacists, etc. applying for and receiving payment.

1927(g)(2)(A)(i)  
42 CFR 456.705(b)

2. Prospective DUR is performed using an electronic point of sale drug claims processing system.

1927(j)(2)  
42 CFR 456.703(c)

J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

• U.S. G.P.O.:1993-342-239:80043

TN No. **93-21**

Supersedes

TN No. **NEW**

Approval Date

**SEP 13 1993**

Effective Date

**APR 1- 1993**

Revision: ~~ECR-AT-90-38 (277)~~  
May 22, 1980

State NEW YORK

Citation  
42 CFR 431.115 (c)  
AT-78-90  
AT-79-74

4.27 Disclosure of Survey Information and Provider or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

Revision: HCFA-PM-93-1  
January 1993

(BPD)

State/Territory: New York

Citation

42 CFR 431.152;  
AT-79-18  
52 FR 22444;  
Secs.  
1902(a)(28)(D)(i)  
and 1919(e)(7) of  
the Act; P.L.  
100-203 (Sec. 4211(c)).

4.28 Appeals Process

- (a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.
- (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

Revision: HCFA-PM-99-3 (CMSO)  
JUNE 1999

State: NEW YORK

Citation

1902(a)(4)(C) of the  
Social Security Act  
P.L. 105-33

4.29

Conflict of Interest Provisions

The Medicaid agency meets the requirements of section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

1902(a)(4)(D) of the  
Social Security Act  
P.L. 105-33

The Medicaid agency meets the requirements of section 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

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TN No. **99-30** DEC 6 1999  
Supersedes Approval Date \_\_\_\_\_ Effective Date JUL 1 1999  
TN No. 86-26

Revision: HCFA-PM-87-14 (BERC)  
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: New York

Citation  
42 CFR 1002.203  
AT-79-54  
48 FR 3742  
51 FR 34772

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

The agency, under the authority of State law, imposes broader sanctions.

TN No. 88-7  
Supersedes  
TN No. 83-34

Approval Date JAN 13 1992

Effective Date JAN 01 1988

HCFA ID: 1010P/0012P

Revision: HCFA-AT-87-14 (BERC)  
OCTOBER 1987

OMB No.: 0938-0193  
4.30 Continued

State/Territory: New York

Citation

(b) The Medicaid agency meets the requirements of--

1902(p) of the Act  
P.L. 100-93  
(secs. 7).

(1) Section 1902(p) of the Act by excluding from participation--

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

(B) Any HMO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that--

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

TN No. 88-7

Supersedes

TN No.

**New**

Approval Date JAN 13 1992

Effective Date JAN 01 1988

HCFA ID: 1010P/0012P

Revision: HCFA-AT-87-14 (BERC)  
OCTOBER 1987

OMB No.: 0938-0193  
4.30 Continued

State/Territory: New York

Citation

1902(a)(39) of the Act  
P.L. 100-93  
(sec. 8(f))

(2) Section 1902(a)(39) of the Act by--

- (A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
- (B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of--

1902(a)(41)  
of the Act  
P.L. 96-272,  
(sec. 308(c))

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act  
P.L. 100-93  
(sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

TN No. 88-7

Superseded

TN No.

**New**

Approval Date JAN 13 1992

Effective Date JAN 01 1988

HCFA ID: 1010P/0012P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (Section 1137 of the Act and 42 CFR 435.940 through 435.960).

(b) ATTACHMENT 4.32-A describes in accordance with 42 CFR 435.948(a)(6) the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

TN#: 10-24 Approval Date: DEC 02 2010  
Supersedes TN#: 83-7 Effective Date: JUL 01 2010

Revision: HCFA-PM-87-14 (BERC)  
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: New York

Citation

1902(a)(48)  
of the Act,  
P.L. 99-570  
(Section 11005)  
P.L. 100-93  
(sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

- (a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.
- (b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

TM No. 88-7

Supersedes

TM No. 87-35A

Approval Date JAN 13 1992

Effective Date JAN 01 1988

HCFA ID: 1010P/0012P

JANUARY 1990

State/Territory: New York

Citation

4.35

Remedies for Nursing Facilities that Do Not Meet Requirements of Participation

1919(h)(1) and (2) of the Act, P.L. 100-203 (Sec. 4213(a))

(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for nursing facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.



(b) The agency uses the following remedy(ies):

- 1) Denial of payment of new admissions. (Direct)
- 2) Civil money penalty (Alternative)
- 3) Appointment of temporary management. (Alternative)
- 4) In emergency cases, closure of the facility and/or transfer of residents. (Direct)

1919(h)(2)(B)(ii) of the Act



(c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.

1919(h)(2)(F) of the Act



(d) The agency uses one of the following incentive programs to reward nursing facilities that furnish the highest quality care to Medicaid residents:



1) Public recognition.



2) Incentive payments.

TN No. 90-19  
Supersedes  
TN No. **New**

Approval Date JAN 26 1990

Effective Date APR 1 - 1990

Revision: HCFA-PM-95-4 (HSQB)  
JUNE 1995

State/Territory: New York State

Citation

42 CFR  
§488.402(f)

4.35 Enforcement of Compliance for Nursing Facilities

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

- (1) nature of noncompliance,
- (2) which remedy is imposed,
- (3) effective date of the remedy, and
- (4) right to appeal the determination leading to the remedy.

42 CFR  
§488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR  
§488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR  
§488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR  
§488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

— The State considers additional factors. Attachment 4.35-A describes the State's other factors.

TN No. 95-33  
Supersedes  
TN No. New

Approval Date: MAR 07 1997

Effective Date: JUL 01 1995

Revision: HCFA-PH-95-4 (HSQB)  
JUNE 1995

State/Territory: New York State

Citation

42 CFR  
§488.410

42 CFR  
§488.417(b)  
§1919(h)(2)(C)  
of the Act.

42 CFR  
§488.414  
§1919(h)(2)(D)  
of the Act.

42 CFR  
§488.408  
§1919(h)(2)(A)  
of the Act.

42 CFR  
§488.412(a)

c) Application of Remedies

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NP's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NP that has not come into substantial compliance within 3 months after the last day of the survey.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

(v) When immediate jeopardy does not exist, the State terminates an NP's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR  
§488.406(b)  
§1919(h)(2)(A)  
of the Act.

(i) The State has established the remedies defined in 42 CFR 488.406(b).

- X (1) Termination
- X (2) Temporary Management
- X (3) Denial of Payment for New Admissions
- X (4) Civil Money Penalties
- X (5) Transfer of Residents; Transfer of Residents with Closure of Facility
- X (6) State Monitoring

X (7) Directed Plan of Correction

X (8) Directed Inservice Training

Attachments 4.35-B through 4.35-J describe the criteria for applying the above remedies.

TN No. 95-33  
Supersedes  
TN No. New

Approval Date: MAR 07 1997

Effective Date: JUL 01 1995

Revision: HCFA-PM-95-4 (HSQB)  
JUNE 1995

State/Territory: New York State

Citation

42 CFR  
§488.406(b)  
§1919(h)(2)(B)(ii)  
of the Act.

(ii)  The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

- (1) Temporary Management
- (2) Denial of Payment for New Admissions
- (3) Civil Money Penalties
- (4) Transfer of Residents; Transfer of Residents with Closure of Facility
- (5) State Monitoring.

Attachments 4.35-8 through 4.35-9 describe the alternative remedies and the criteria for applying them.

42 CFR  
§488.303(b)  
1910(h)(2)(F)  
of the Act.

(e)  State Incentive Programs

- (1) Public Recognition
- (2) Incentive Payments

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: New York

Citation 4.36 Required Coordination Between the Medicaid and WIC Programs

1902(a)(11)(C)  
and 1902(a)(53)  
of the Act

The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

TN No. 91-25  
Superseded New Approval Date MAR 3 1992 Effective Date OCT 1 1991  
TN No. New

HCFA ID: 7982E

Revision: HCFA-PH-91-10  
DECEMBER 1991

(BFD)

State/Territory: New York

Citation

42 CFR 483.75; 42  
CFR 483 Subpart D;  
Secs. 1902(a)(28),  
1919(e)(1) and (2),  
and 1919(f)(2),  
P.L. 100-203 (Sec.  
4211(a)(3)); P.L.  
101-239 (Secs.  
6901(b)(3) and  
(4)); P.L. 101-508  
(Sec. 4801(a)).

4.38 Nurse Aide Training and Competency  
Evaluation for Nursing Facilities

- (a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
- (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
- (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
- (d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
- (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
- XX (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

TN No. 92-05  
Supersede  
TN No. New

Approval Date APR 19 1992

Effective Date JAN 1

State/Territory: New York

Citation

42 CFR 483.75; 42  
CFR 483 Subpart D;  
Secs. 1902(a)(28),  
1919(e)(1) and (2),  
and 1919(f)(2),  
P.L. 100-203 (Sec.  
4211(a)(3)); P.L.  
101-239 (Secs.  
6901(b)(3) and  
(4)); P.L. 101-508  
(Sec. 4801(a)).

- (g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.
- (h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
- (i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
- (j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
- (k) For program reviews other than the initial review, the State visits the entity providing the program.
- (l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

TN No. 92-05  
Supersedes New  
TN No. New

Approval Date APR 15 1992

Effective Date JAN 1

State/Territory: New York

Citation  
42 CFR 483.75; 42  
CFR 483 Subpart D;  
Secs. 1902(a)(28),  
1919(e)(1) and (2),  
and 1919(f)(2),  
P.L. 100-203 (Sec.  
4211(a)(3)); P.L.  
101-239 (Secs.  
6901(b)(3) and  
(4)); P.L. 101-508  
(Sec. 4801(a)).

- (m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
- (n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
- (o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
- (p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
- XX (q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
- (r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

TN No. 02-05  
Supersedes  
TN No. New

Approval Date APR 10 1992

Effective Date JAN 1

State/Territory: New York

Citation

42 CFR 483.75; 42  
CFR 483 Subpart D;  
Secs. 1902(a)(28),  
1919(e)(1) and (2),  
and 1919(f)(2),  
P.L. 100-203 (Sec.  
4211(a)(3)); P.L.  
101-239 (Secs.  
6901(b)(3) and  
(4)); P.L. 101-508  
(Sec. 4801(a)).

- (s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.
- (t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
- (u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
- (v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
- (w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
- (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
- (y) The State has a standard for successful completion of competency evaluation programs.

92-05  
TN No. Supersedes New  
TN No.

Approval Date APR 10 1992

Effective Date JAN 1

Revision: HCFA-FH-91-10  
DECEMBER 1991

79E  
(BFD)

State/Territory: New York

Citation  
42 CFR 483.75; 42  
CFR 483 Subpart D;  
Secs. 1902(a)(28),  
1919(e)(1) and (2),  
and 1919(f)(2),  
P.L. 100-203 (Sec.  
4211(a)(3)); P.L.  
101-239 (Secs.  
6901(b)(3) and  
(4)); P.L. 101-508  
(Sec. 4801(a)).

- (z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
- XX (aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
- (bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
- (cc) The State includes home health aides on the registry.
- VY (dd) The State contracts the operation of the registry to a non State entity.
- XX (ee) ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
- XX (ff) ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

TN No. 92-05  
Superseded  
TN No. New

Approval Date APR 29 1992

Effective Date JAN 1

Revision: HCFA-PM-93-1 (BPD)  
January 1993

State/Territory: New York

Citation  
Secs.

1902(a)(28)(D)(i)  
and 1919(e)(7) of  
the Act;  
P.L. 100-203  
(Sec. 4211(c));  
P.L. 101-508  
(Sec. 4801(b)).

4.39 Preadmission Screening and Annual  
Resident Review in Nursing Facilities

- (a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).
- (b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.
- (c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.
- (d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.
- (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

TN No. 93-14

Supersedes

TN No. New

Approval Date JUN 28 1993

Effective Date JAN 1 - 1993

Revision: HCFA-PM-93-1 (BPD)  
January 1993

State/Territory: New York

4.39 (Continued)

- (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.
- (g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

TN No. 93-14  
 Supersedes  
 TN No. New Approval Date JUN 28 1993 Effective Date JAN 1 - 1993

APRIL 1992

OMB No.:

State/Territory: New York

Citation

4.40 Survey & Certification Process

Sections  
1919(g)(1)  
thru (2) and  
1919(g)(4)  
thru (5) of  
the Act P.L.  
100-203  
(Sec.  
4212(a))

1919(g)(1)  
(B) of the  
Act

1919(g)(1)  
(C) of the  
Act

(a) The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.

(b) The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.

(c) The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State's process.

(d) The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency?

(e) The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.

(f) The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

92-37

TN No.

Supersedes

TN No.

New

Approval Date JAN 31 1995

Effective Date APR 1 - 1992

HCFA ID: \_\_\_\_\_

State/Territory: New York

- 1919(g)(2)  
(A)(1) of  
the Act
- (i) The State has procedures, as provided for at section 1919(g)(2)(A)(1), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.
- 1919(g)(2)  
(A)(ii) of  
the Act
- (ii) The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
- 1919(g)(2)  
(A)(iii)(I)  
of the Act
- (i) The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
- 1919(g)(2)  
(A)(iii)(II)  
of the Act
- (j) The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
- 1919(g)(2)  
(B) of the  
Act
- (k) The State conducts extended surveys immediately or, if not practicable, not later than 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
- 1919(g)(2)  
(C) of the  
Act
- (l) The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

Revision: HCFA-PM-92-3  
APRIL 1992

79w 79w  
(HSQB)

OMB No:

State/Territory: New York

- 1919(g)(2)  
(D) of the  
Act (r) The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.
- 1919(g)(2)  
(E)(i) of  
the Act (s) The State uses a multidisciplinary team of professionals including a registered professional nurse.
- 1919(g)(2)  
(E)(ii) of  
the Act (c) The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
- 1919(g)(2)  
(E)(iii) of  
the Act (p) The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
- 1919(g)(4)  
of the Act (c) The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures.
- 1919(g)(5)  
(A) of the  
Act (r) The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
- 1919(g)(5)  
(B) of the  
Act (s) The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
- 1919(g)(5)  
(C) of the  
Act (c) If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
- 1919(g)(5)  
(D) of the  
Act (u) The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

92-37  
TN No. 92-37  
Supersedes  
TN No.

Approval Date JAN 31 1995

Effective Date APR 1 - 1992

HCFA ID:           

**New**

Revision: HCFA-PM-92- 2  
MARCH 1992

(HSQB)

State/Territory: New York

Citation

4.41 Resident Assessment for Nursing Facilities

Sections  
1919(b)(3)  
and 1919  
(e)(5) of  
the Act

(a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.

1919(e)(5)  
(A) of the  
Act

(b) The State is using:

\_\_\_\_\_ the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or

1919(e)(5)  
(B) of the  
Act

X a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

92-23

TN No. \_\_\_\_\_  
Supersedes \_\_\_\_\_ Approval Date JUL 30 1992 Effective Date APR 1 1992  
TN No. New HCFA ID: \_\_\_\_\_

**OFFICIAL**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

Citation  
1902(a)(69) of  
the Act,  
P.L. 109-171  
(section 6034)

4.43 Cooperation with Medicaid Integrity Program Efforts.  
The Medicaid agency assures it complies with such requirements  
determined by the Secretary to be necessary for carrying out the  
Medicaid Integrity Program established under Section 1936 of the  
Act.

TN No. 08-59  
Supersedes  
TN No. New

Approval Date: JUL 29 2008

Effective Date: APR 01 2008

**New**

Revision: ~~EPA-AT-80-38 (SFP)~~  
 May 22, 1980

State New York

**SECTION 5 PERSONNEL ADMINISTRATION**

Citation  
 42 CFR 432.10(a)  
 AT-78-90  
 AT-79-23  
 AT-80-34

**5.1 Standards of Personnel Administration**

- (a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

TN # 77-37  
 Supersedes  
TN # 76-10

Approval Date 12/28/77

Effective Date 9/28/77

Revision: ~~SA-AT-80-13 (FP)~~  
May 22, 1980

State New York

5.2 [Reserved]

IV # \_\_\_\_\_  
Supersecas  
IV # \_\_\_\_\_

Approval Date \_\_\_\_\_

Effective Date \_\_\_\_\_

Revision: ~~AT-80-33 (27)~~  
 May 22, 1980

State New York

Citation  
 42 CFR Part 432,  
 Subpart B  
 AT-78-90

5.3 Training Programs; Subprofessional and  
 Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

TN # 78-1  
 Supercedes  
TN # 77-37

Approval Date 4/3/78 Effective Date 2/27/78

Revision: ~~HEA-AT-86-38 (EFP)~~  
 May 22, 1980

State New York

**SECTION 6 FINANCIAL ADMINISTRATION**

Citation  
 42 CFR 433.32  
 AT-79-29

**6.1 Fiscal Policies and Accountability**

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

EN # 74-2  
 Supersedes  
 EN # None

Approval Date 12/31/74

Effective Date 1/1/74

State NEW YORK

Citation:  
42 CFR 433.34  
47 FR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

TN # 83-3  
Supersedes  
TN # 76-15

Approval Date 8 APR 1983

Effective Date January 1, 1983

Revision: ~~227A~~-AT-80-38 (257)  
May 22, 1980

State                      New York

Citation  
42 CFR 433.33  
AT-79-29  
AT-80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

State funds are used to pay all of the non-Federal share of total expenditures under the plan.

There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

IN # 74-2  
Supersedes  
IN # None  
[For 6.3(w)]  
FNU# 77-41  
Supersedes  
TV# 74-2

Approval Date 12/31/74

Effective Date 11/1/74 <sup>Prior To</sup>

Approval Date 3/18/78

Effective Date 10/1/77

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

OMB No. 0938-

State/Territory: New York

SECTION 7 - GENERAL PROVISIONS

Citation

7.1 Plan Amendments

42 CFR 430.12(c)

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

TN No. 91-75  
Supersedes TN No. 74-2 Approval Date MAR 5 1992 Effective Date OCT 1 1991

HCFA ID: 7982E

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

OMB No. 0938-

State/Territory: New York

Citation 7.2 Nondiscrimination

45 CFR Parts  
80 and 84

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

TN No. 91-75

Supersedes

TN No. 79-11

Approval Date

MAR 3 1992

Effective Date

OCT 1 1991

HCFA ID: 7982E



Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No. 0938-

State/Territory: New York

Citation 7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

- Not applicable. The Governor--
- Does not wish to review any plan material.
- Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

New York State Department of Health  
(Designated Single State Agency)

Date: September 6, 1996

*Babara A. DeMarco, MS*

(Signature)

Commissioner

(Title)

TN No. 96-33  
 Supersedes 91-75 Approval Date NOV 04 1996 Effective Date DEC 1 1996  
 TN No. 91-75

HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT Attachment 1.1-A  
MEDICAL ASSISTANCE PROGRAM

State of New York

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

The New York State Department of Health is the  
single State agency responsible for:

administering the plan.

The legal authority under which the agency administers  
the plan on a Statewide basis is

(statutory citation)

supervising the administration of the plan by local  
political subdivisions.

The legal authority under which the agency supervises  
the administration of the plan on a Statewide basis is  
contained in

Section 363-a of the Social Services Law and  
Section 201 of the Public Health Law

(statutory citation)

The agency's legal authority to make rules and regulations  
that are binding on the political subdivisions administer-  
ing the plan is

Section 363-a of the Social Services Law and  
Sections 201 and 206 of the Public Health Law

(statutory citation)

September 17, 1996  
DATE

*Dennis V. Vano*  
Signature

Attorney General  
Title

TN 96-33 Approval Date NOV 04 1996

State of New York 74-2

WAIVER(S) OF THE SINGLE STATE AGENCY REQUIREMENT GRANTED  
UNDER THE INTERGOVERNMENTAL COOPERATION ACT OF 1968

Waiver #1. <sup>1/</sup>

Limited

a. Waiver was granted on May 11, 1969

(date)

b. The organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to Department of Mental Hygiene, and

(NAME OF AGENCY)

the resources and/or services of such agency to be utilized in administration of the plan are described below:

Permits State funds to be appropriated directly to the Department of Mental Hygiene for medical assistance under Title XIX for patients in State mental hospitals and schools for the mentally retarded.

Waiver #2: Granted 7/24/70 Department of Mental Hygiene and  
Narcotics Addiction Control Commission

Limited waiver permits State funds to be appropriated directly to the Department of Mental Hygiene and Narcotics Addiction Control Commission for Intermediate Care Facilities services under Title XVI. (Now Title XIX)

Waiver #3: Granted 7/1/71 Department of Health

Limited waiver permits State funds to be appropriated directly to Department of Health for administering and supervising the medical aspects of Title XIX Program.

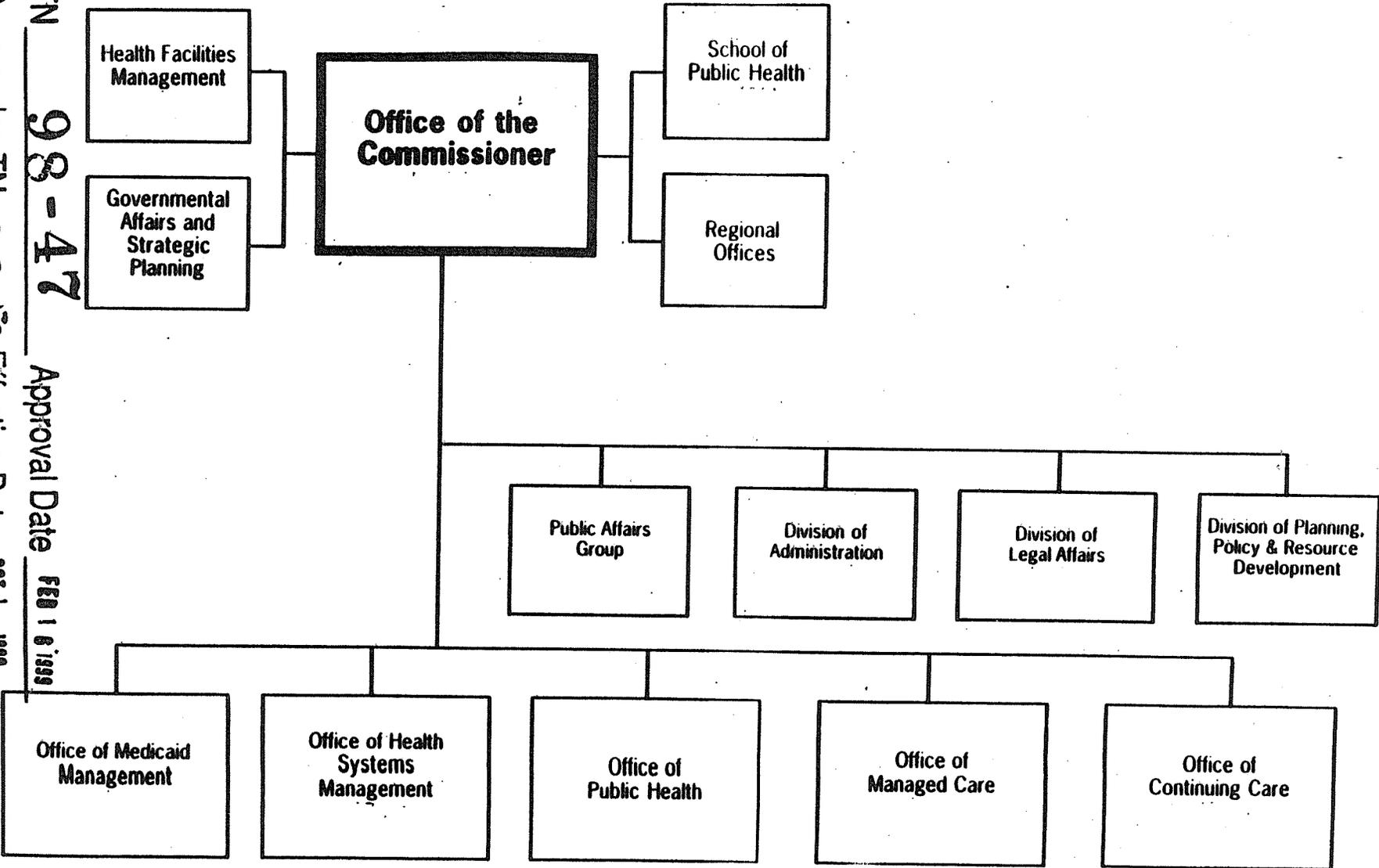
1/ (Information on any additional waivers which have been granted is contained in attached sheets.)

- c. The methods for coordinating responsibilities among the several agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

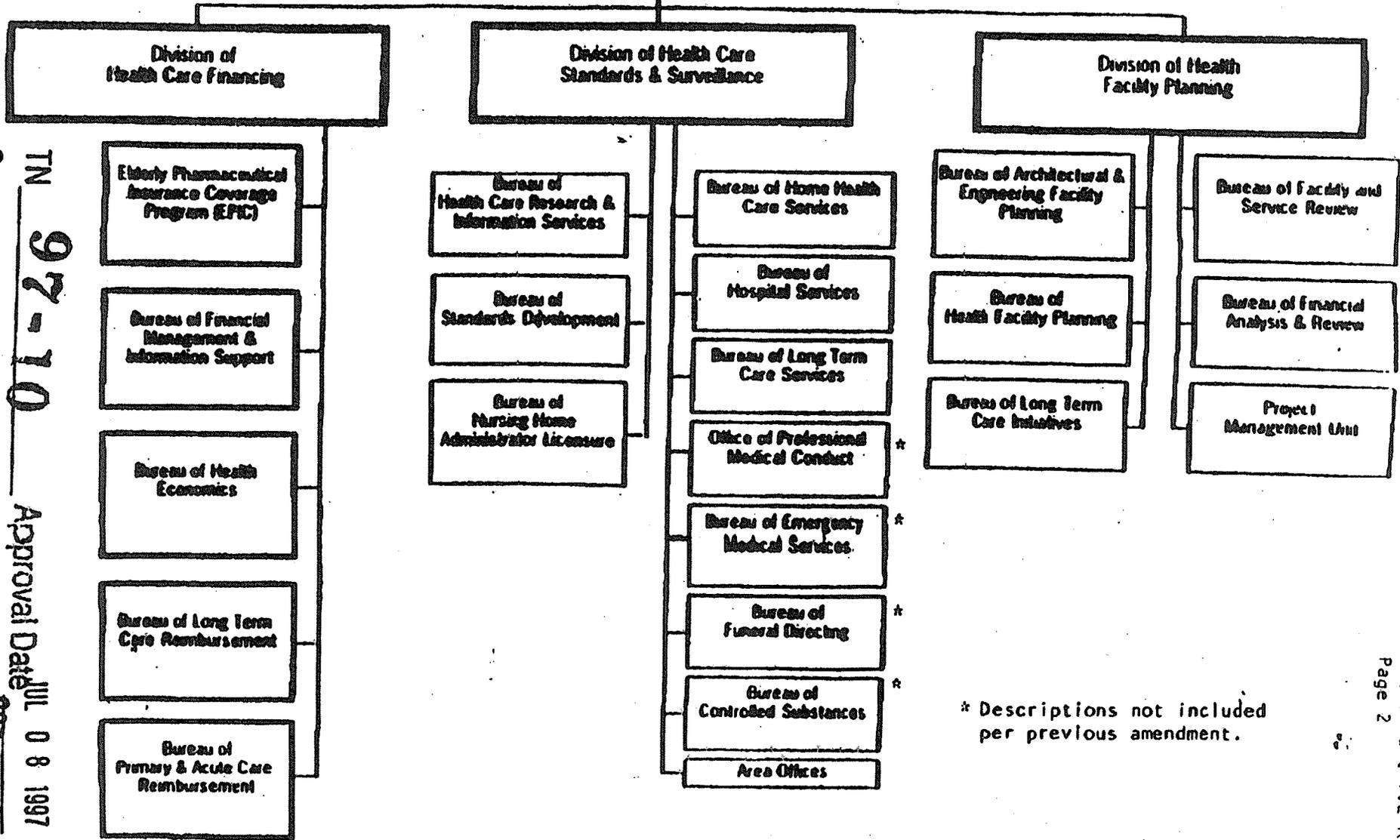
Under Title 11 of the Social Services Law, the Department of Social Services has the responsibility of assuring the accuracy of the claims presented for Federal reimbursement under Title XIX. As the Single State Agency it is responsible for auditing the Title XIX expenditures of the Departments of Health, Mental Hygiene, and the Narcotics Addiction Control Commission.

Under Section 1, Article V of the New York State Constitution and Section 8, Article 2 of the State Finance Law, the State Comptroller has audit responsibility for examination of expenditures, accounts, revenues, and receipts. He is responsible for all fiscal matters, including the accounting systems in State department and agencies. For this reason, the State Comptroller is responsible for conducting audits of Title XIX expenditures made by the Departments of Mental Hygiene, Health and the Narcotics Addiction Control Commission, and for reviewing the methods of accounting used by these departments. Under U.S. Bureau of the Budget Circular 4-67 we claim for the indirect costs of the services performed by the Department of Audit and Control on behalf of our Federal programs. These indirect costs include the Comptroller's audit functions on behalf of our Title XIX Medicaid Program.

Supersedes TN 97-10 Effective Date Oct 1 1998  
TN 98-47 Approval Date FEB 1 6 1999



# Office of Health Systems Management



New York

\* Descriptions not included per previous amendment.

Supersedes TN 85-8 Effective Date  
 TN 97-10 Approval Date JUL 08 1997  
 OCT 01 1996

**Organizational Unit: Division of Health Care Standards and Surveillance**

The responsibilities discharged through the Division of Health Care Standards and Surveillance support the Department's mandated purposes of protecting, promoting and preserving the health of the residents of New York State. The Division's activities, include setting the minimum inspection of facilities needed to monitor and enforce those standards to safeguard the health of the State's entire population, regardless of geographic location or ability to pay. From the newborns in hospitals to the elderly in nursing homes, the constant surveillance of the full spectrum of medical services provided to the State's varied population groups serves to reduce morbidity and mortality by enduring that those services meet Federal and State requirements. This surveillance process includes not only the routine inspection of providers, but also the investigation of all complaints received. Whether they are the frail elderly of the State's population, or the developmentally disabled children, the surveillance of health care providers helps to ensure that the quality of their lives reaches optimal levels.

The Division discharges its responsibilities through two groups, the Health Care Standards and Analysis Group and the Health Care Surveillance Group.

The Health Care Standards and Analysis Group is comprised of the following bureaus:

1. Bureau of Standards Development
2. Bureau of Health Care Research and Information Services
3. Bureau of Nursing Home Administrator Licensure

The Health Care Surveillance Group is comprised of the following three bureaus:

1. Bureau of Hospital Services
2. Bureau of Long Term Care Services

TN 97-10 Approval Date JUL 08 1997  
Supersedes TN 85-8 Effective Date OCT 01 1996

New York

Attachment 1.2-A  
Page 4

**3. Bureau of Home Health Care Services**

The Group's surveillance function is discharged through area offices located in Albany, Buffalo, Rochester, Syracuse, New York City and New Rochelle. In addition, the New Rochelle area office operates a sub-office on Long Island.

Staff resources are directed toward meeting objectives which will ensure the provision of accessible, efficient, effective and high quality health care services.

TN 97-10 Approval Date JUL 08 1997  
Supersedes TN New Effective Date OCT 01 1998

**Organizational Unit: Bureau of Standards Development**

The Bureau develops health care standards necessary to implement Federal and State legislation applicable to all types of health care providers and services. These standards include facility or agency operating standards and standards governing the quality and availability of services provided under the Medical Assistance Program (Medicaid). In addition to the revision and modification of standards related to established forms of health care services, the Bureau is responsible for the formulation of standards dealing with new and innovative program areas. The Bureau also staffs the Code Committee of the State Hospital Review and Planning Council.

The Bureau, through its Pharmacy Unit, maintains the list of drugs eligible for reimbursement under the NYS Medicaid program, and the list of drugs eligible to be substituted for brand name prescription drugs under the NYS Generic Drug Substitution Program. Pharmaceutical provider plans, to ensure compliance with the Drug Imprinting and Labeling Law, are monitored by the Pharmacy Unit. In addition, support is provided to the EPIC (Elderly Pharmaceutical Insurance Coverage) program to determine the appropriateness of drugs covered under that program.

The Bureau has responsibility for the administration of Medical Assistance Program training funds and assists in the development of specific training initiatives.

The Bureau serves as the primary resource to the OHSM on the qualifications and scope of practice of particular professions. The staff includes administrative as well as professional personnel in various clinical care disciplines including dentistry, medicine, nursing, occupational therapy, pharmacy, and social work.

TN 97-10 Approval Date JUL 08 1997  
Supersedes TN New Effective Date OCT 01 1996

Organizational Unit: Bureau of Health Care Research and Information Serv

The Bureau of Health Care Research and Information Services (BHCR/IS) staff generate and maintain data registries in support of the Division's standard setting and surveillance activities and coordinate health care research and analysis activities throughout the Division. These services, provided through the use of quantitative analysis, management science and electronic data processing, enhance the Division's ability to meet its objective of assuring that the State's health system provides high quality care, thus reducing morbidity and mortality.

The Bureau has four organizational units:

- o Systems Development: This unit is responsible for the planning and implementation of mainframe user systems and user portions of production systems that support the regulatory missions of the Division.
- o Policy Analysis: This unit is responsible for providing quantitative policy analysis and program evaluation services to the regulatory bureaus within the Division and to OHSM executive staff.
- o Personal Computer/Data Communications Support and Application Programming: This unit is responsible for the completion of all special purpose computer programming tasks requested by executive or program staff, and for the installation and support of PC equipment, terminals and printers throughout the Division.
- o Information Systems and Health Statistics Group (ISHS) Liaison: An individual has been designated for lead responsibility in coordinating day-to-day contacts between Division staff and ISHS. In addition to facilitating Divisional access to ISHS services, this arrangement provides a quasi-management link to the production programmers assigned to the Division.

TN 97-10 Approval Date JUL 08 1997  
Supersedes TN New Effective Date OCT 01 1998

Organizational Unit: Bureau of Nursing Home Administrator Licensure

The activities of the Bureau of Nursing Home Administrator Licensure help to ensure the provision of appropriate and necessary health care services to the chronically ill and frail elderly population residing in nursing homes in New York State.

The Bureau of Nursing Home Administrator Licensure (BNHAL) services as staff to the New York State Board of Examiners of Nursing Home Administrators. The Board is responsible for establishing standards of education, training, and experience and providing for the examination, licensure, and registration of nursing home administrators in New York State. Currently, there are 3,650 individuals licensed as nursing home administrators in New York State.

The Board is also responsible for initiating disciplinary action against administrators who violate provisions of Article 28-D of the Public Health Law, which defines the practice of nursing home administration. The Board may suspend, revoke, annul or censure the license or registration of an administrator for violations of the Public Health law. In addition, the Board may assess civil penalties against administrators when it deems appropriate.

TN 97-10 Approval Date JUL 08 1997  
Supersedes TN New Effective Date OCT 01 1996

Organizational Unit: Bureau of Home Health Services (HHS)

The Bureau of Home Health Services has six primary areas of program responsibility: 1) regulation and certification of Certified Home Health Agencies (CHHA), 2) licensure and regulation of home care service agencies, 3) development and implementation of the Long Term Home Health Care Program (LTHHCP), 4) certification and regulation of the Hospice program, 5) development, implementation and evaluation of the Chapter 831 Home Health Care Grant program and Home Health Grant Training program, and 6) provision of staff support to the State Council on Health Care Services. The Bureau is responsible for coordinating the activities of program staff in these areas through the six OHSM area offices.

The development of cost effective and high quality noninstitutional alternatives is the common thread which unifies the Bureau's major responsibilities. Each major program area is developmental in nature when compared to the more traditional forms of health delivery. A major focus of Bureau activity is the creation and implementation of innovative surveillance protocols for assuring quality in the care delivered by such programs. The facilitation and revision of legislation, regulations, and policies to create the proper environment for the development and competitive existence of home based programs is also a major component of such ongoing activities.

TN 97-10 Approval Date JUL 08 1997  
Supersedes TN Now Effective Date OCT 01 1996

Organizational Unit: Bureau of Hospital Services

The primary goal of the Bureau of Hospital Services is to promote and assure the quality of inpatient, outpatient and emergency room care provided in the 268 hospitals established under Article 28 of the Public Health Law..

In the assurance of regulatory compliance, the Bureau's programs include a comprehensive Article 28 survey program, targeted Article 28 surveys, complaint investigation surveys, the incident reporting program, character and competence reviews as part of the certificate of need process, and Title XVIII surveys. In addition, the Bureau initiates enforcement actions against facilities to ensure regulatory compliance.

During the 1988-89 fiscal year, the Department consolidated its Utilization Review (UR) program, and as a result, the Department now has one Medicaid UR agent for upstate New York (Network Design Group) and one for the New York City and Long Island region (Island Peer Review Organization). The actual review activity is being conducted through contractual arrangements with these two medical review groups.

#### Comprehensive Article 28 Survey Program

The comprehensive Article 28 survey program is designed to focus on patient outcomes through the assessment of quality of patient care and the effectiveness of internal hospital quality assurance systems.

TN 97-10 Approval Date JUL 08 1997  
Supersedes TN New Effective Date OCT 01 1998

## Organizational Unit: BUREAU OF LONG TERM CARE SERVICES

The Bureau of Long Term Care Services is the central program office responsible for the Office of Health Systems Management's long term care regulatory activities. The Bureau is responsible for directing the area office surveillance program as specified by the Health care Financing Administration under the 1864 Agreement designating the Department of Health as the state surveillance agent for nursing homes. The program is required to enforce facility operating standards and monitor the quality of care delivered to approximately 103,714 patients/residents residing in 628 long term care facilities as specified in Titles XVIII/XIX of the Federal Social Security Act and Article 28 of the Public Health Law.

As the central, coordinative point for the survey process, the Bureau must assure that long term care standards are enforced effectively and uniformly throughout the State. The Bureau's activities are directed at ensuring that the State's skilled nursing facilities are providing all services and care necessary to enable each resident to achieve his or her highest practicable level of physical, mental, and psychosocial well-being as required by federal regulation.

The activities of the Bureau of Long Term Care Services are carried out by three separate units within the Bureau: (1) Quality Assurance, Complaint Investigation, and Enforcement; (2) Surveillance Program Operations and Development; and (3) Facility Operations and Control.

TN 97-10 Approval Date JUL 08 1997  
Supersedes TN New Effective Date OCT 01 1996

Organizational Unit: Division of Health Facility Planning

The Division of Health Facility Planning, funded within the Health Care Standards and Surveillance program, is responsible for the administration of the State's Certificate of Need (CON) activities. The State mandated CON program provides a planning mechanism to ensure that health care resources are developed and made available to the public in a comprehensive, coordinated manner which is responsive to the public's health care needs. Each proposal is evaluated based on community need for beds and services, financial feasibility and cost efficiency of the project, and the competence and character of the sponsors. The review of CON applications and determination of need provide a vital step in achieving the Department's goal of quality care for all that is affordable and accessible.

In addition to its responsibility for administering the State's CON program, the Division is involved in activities designed to improve the efficiency of the existing health care network. Through examination of specific facilities and services, the Division makes recommendations regarding the merger or consolidation of facilities and changes in services to more appropriately reflect factors such as utilization and facility financial status.

The Division is composed of two groups: The Health Facility Planning Group and the Certificate of Need Review Group.

The Health Facility Planning Group is composed of two groups: The Health Facility Planning Group and the Certificate of Need Review Group.

The Health Facility Planning Group is composed of two bureaus:

1. Bureau of Health Facility Planning
2. Bureau of Architectural and Engineering Facility Planning

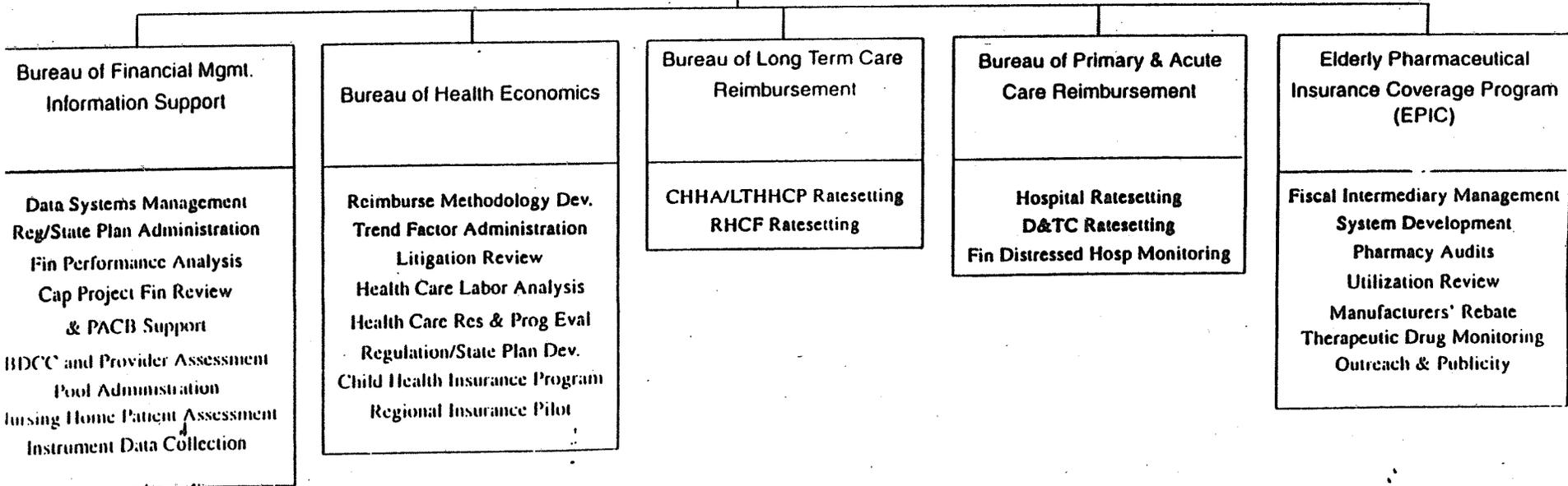
The Certificate of Need Review Group is composed of two bureaus and one unit:

1. Bureau of Facility and Service Review
2. Bureau of Financial Analysis and Review
3. Project Management Unit

TN 97-10 Approval Date JUL 08 1997  
Supersedes TN New Effective Date OCT 01 1998

# Division of Health Care Financing

Office of Deputy Director



TN 97-10 Approval Date JUL 08 1997  
 Supersedes TN New Effective Date OCT 01 1996

**DIVISION OF HEALTH CARE FINANCING**

The Division of Health Care Financing is organizationally responsible for ensuring that health care resources are most appropriately allocated. Financial management of New York State's health care system is accomplished through a variety of activities. They include developing reimbursement methodologies, setting third party reimbursement rates, administering State revenue collection programs generated through various assessments charged to health care providers, and reviewing the financing mechanisms of proposed health facility construction and expansion projects. Alternative health care financing mechanisms that offer potential cost control incentives and savings are also examined, tested and evaluated.

The following units are responsible for carrying out the duties of the Division:

1. Bureau of Health Economics
2. Bureau of Primary and Acute Care Reimbursement
3. Bureau of Financial Management and Information Support
4. Bureau of Long Term Care Reimbursement

**THE MAJOR RESPONSIBILITIES OF THE DIVISION INCLUDE:**

- Calculating and/or promulgating and approving rates of payment for hospitals, residential health care facilities, diagnostic and treatment centers, home health agencies, and other Article 28, 36, 40, 43, and 44 certified facilities.
- Adjudicating appeals to rates of payment consistent with regulations and statute.
- Developing and evaluating new and alternative financing methods for health care providers and insurers. These financing methods include improving methods of pricing health care services, refining patient provider encounters, and examining capital financing methods and utilizing insurance vehicles for providing health care services for the uninsured and underinsured.
- Administering several grant programs for global budgeting, health networks and health care demonstrations.
- Developing and implementing sponsored health care financing research activities.

TN 97-10 Approval Date JUL 08 1997

- Establishing and administering the financing reforms detailed in the Health Care Reform Act of 1996. Developing policies, procedures and protocols that will, for the first time, allow New York to move to negotiated rates for hospital care and will continue support of public policy priorities including uncompensated care, graduate medical education and numerous health care initiatives.
- Administering approximately \$2.0 billion in pooled funds financed through health care provider and insurer assessments and surcharges for medically indigent subsidies, various health care project initiatives, graduate medical education and physician excess malpractice coverage.
- Administering collection of statutory assessments on health care providers pertaining to the Health Facility Cash Receipts Assessment Program, and the HMO Differential.
- Maintaining the Patient Review Instrument (PRI) processing system, including collection of data via electronic mail, correction of data, auditing of data, assignment of Resource Utilization Group (RUG), and updating of Residential Health Care Facility (RHCF) rates to reflect changes in case mix index (CMI).
- Collecting cost report data via electronic mail for five provider groups; hospitals, RHCFs, Diagnostic & Treatment Centers (D&TCs), Certified Home Health Agencies (CHHAs), and Long Term Home Health Care Programs (LTHHCPs).
- Providing financial analysis services to State mortgage loan programs which provide construction financing to non-profit nursing homes and hospitals.
- Designing and evaluating payment methodologies for hospitals, nursing homes and ambulatory care programs which includes conducting research studies to support Departmental policy recommendations concerning payment for and delivery of health care services; preparing Title XIX (Medicaid) State Plans for health care services which are submitted to the federal government to procure Medicaid federal financial participation; drafting regulations to implement reimbursement methodologies; preparing responses to litigation brought against the Department by providers pertaining to reimbursement methodologies; responding to inquiries from industry, other State agencies, legislative staff and the general public regarding the Medicaid financing systems; and, developing grant applications to procure outside funding for research on financing issues and economic analyses of health care systems.

TN 97-10 Approval Date JUL 08 1997  
Supersedes TN New Effective Date OCT 01 1998

- Coordinating the development of all new Medicaid Program finance regulations and providing administrative services to the State Hospital Review and Planning Council, Fiscal Policy Committee and Medical Advisory Committee.
- Ensuring compliance with Federal statutory requirements relating to the State's provider tax programs. This includes preparation of any necessary waiver applications, and corresponding statistical testing and analysis, pursuant to Federal law.
- Ensuring compliance with Federal Disproportionate Share payment limitations. This includes projecting hospital distributions, Medicaid and uninsured net revenue/losses and implementing such limits into the pool distribution process.
- Monitoring the Receivership Program and its related Receivership Fund, calculating capital costs, monitoring the Article 28-A Mortgage Program and controlling its related Operating Escrow Account activities.
- Monitoring and evaluating the uniform physician billing form and electronic claims submission legislative requirements, including coordination of the activities of the Physician Claim Task Force.

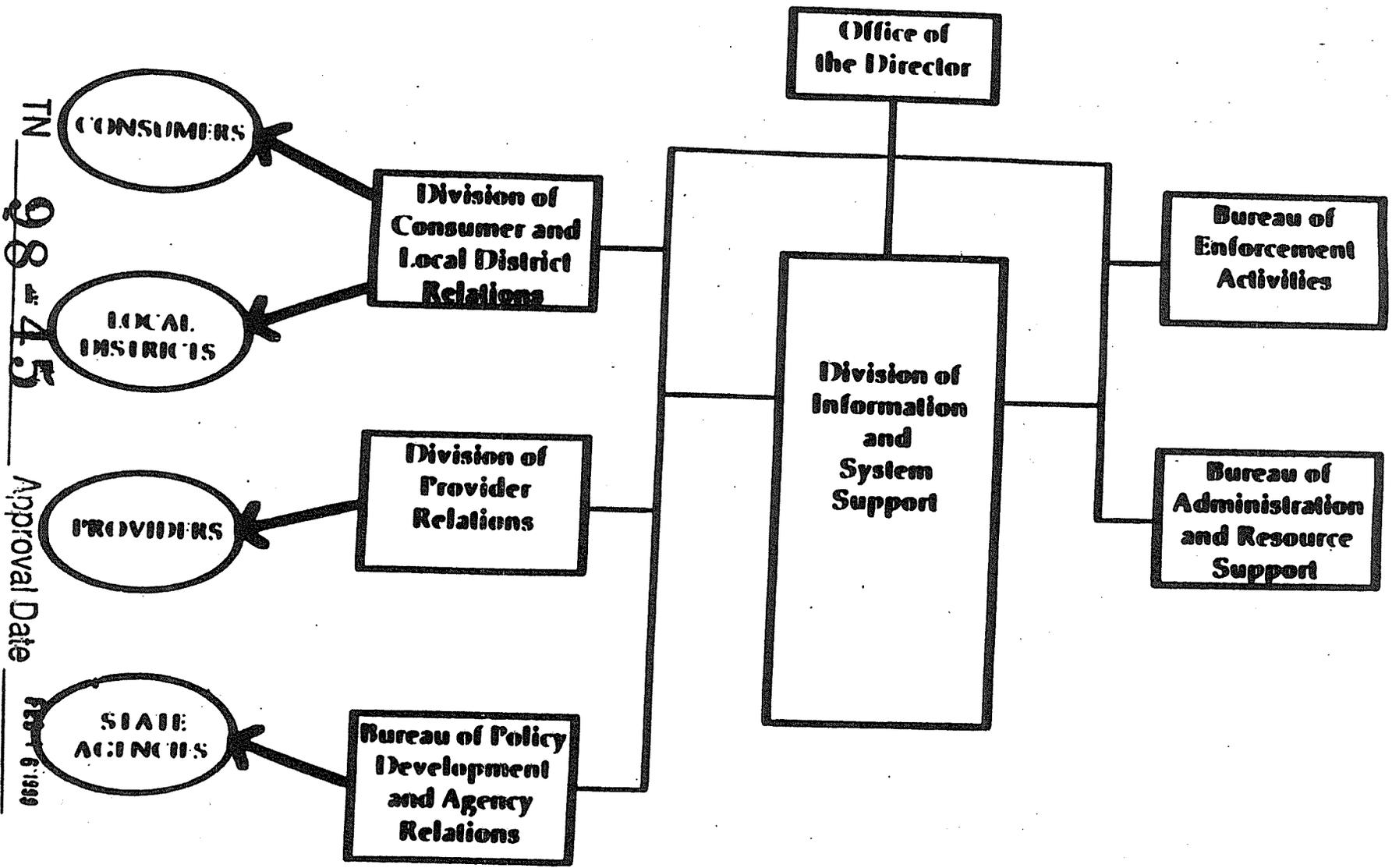
TN 97-10 Approval Date JUL 08 1997  
Supersedes TN New Effective Date OCT 01 1996

Organizational Unit: Elderly Pharmaceutical Insurance Coverage Program  
(EPIC)

The Elderly Pharmaceutical Insurance Coverage (EPIC) program provides assistance to low and moderate income elderly through subsidizing the costs of their prescription medications. As of March 1990, over 76,000 seniors were enrolled in EPIC. Since the program began in October 1987, EPIC has saved these older New Yorkers over \$52 million on the costs of their medications.

The program performs outreach and promotion to inform seniors about the program, enrolls eligible persons, supervises a large contractual operation which processes payments to pharmacies and participants, and performs audits of both the contractor and the providers to assure the fiscal integrity of program operations. In addition, a utilization review function assists in the detection of potential fraud or abuse, research is completed on various aspects of program participation and utilization, and a process for reconsideration and fair hearing is maintained to address participant and provider disputes.

TN 97-10 Approval Date JUL 08 1997  
Supersedes TN New Effective Date OCT 01 1997



TN 98 # 45  
Approval Date FEB 6 1999  
OCT 1 1999  
Sersedas TN 97-10  
Effective Date

New York

**Office of the Director**

The Office of the Director leads and supports the work of the Office of Medicaid Management (OMM). The Director's Office performs the following functions:

- Provide ambassadorship to the outside world
- Works with Department of Health (DOH) executives on high-level DOH management and strategy
- Leads the overall internal functioning of OMM
- Serves as a resource to OMM managers to clarify director's views on emerging issues
- Establishes and holds division heads accountable for performance agreements

TN 98-45 Approval Date FEB 18 1998  
Superceded by 97-10 Effective Date OCT 1 1998

New York

**Bureau of Administration & Resource Support**

The Bureau of Administration and Resource Support provides the other OMM units with the necessary resources to produce OMM's expected results. The Bureau performs the following functions:

- Forecasts and plans resources
- Allocates resources to the divisions and bureaus
- Manages and tracks financial State Purposes expenditures
- Coordinates the preparation of budget initiatives
- Acquires human resources necessary to support program needs
- Secures materials and equipment needed by OMM units
- Space planning
- Day-to-day operational needs

TN 98-45 Approval Date FEB 1 8 1990  
Supersedes TN 97-10 Issue Date OCT 1 1988

New York

**Division of Consumer and Local District Relations**

The Division of Consumer and Local District Relations will help serve both OMM consumers and local governments. The Division will perform the following functions:

- Create eligibility guidelines
- Determine consumer eligibility (including Third Party Liability and disability reviews)
- Provide local district support (technical assistance, training, transportation)
- Resolving consumer complaints
- Assessing performance of local districts
- Educating consumers
- Connecting consumers to the correct services

TN 92-15 Approval Date FEB 16 1998  
Supersedes TN 97-10 Effective Date OCT 1 1998

New York

**Division of Information and System Support**

The Division of Information and System Support will manage and support the information and system needs of the entire OMM organization. The Division will perform the following functions:

- Developing systems (planning, coordination and testing)
- Procuring and monitoring system contracts
- Monitoring and correcting the work of systems contractors
- Responding to data requests
- Developing and supporting OMM's internal PC/LAN system (strategic planning, maintenance, Internet access, help desk)

TN 98-45

Approval Date FEB 16 1999

Supersedes TN 97-10

Effective Date OCT 1 1998

New York

**Bureau of Enforcement Activities**

The Bureau of Enforcement Activities will combat actions of those groups and individuals who fail to comply with Medicaid and OMM rules and regulations. The Bureau will perform the following functions:

- Confirm occurrences of Medicaid fraud (investigation processing)
- Penalizing (sanctioning) providers guilty of Medicaid fraud
- Penalizing (sanctioning) recipients guilty of Medicaid fraud
- Actualizing due process
- Supporting prosecution with/by other law enforcement authorities
- Establishing and maintaining internal controls for OMM

TN 98-45 Approval Date FEB 16 1998  
Supersedes TN 97-10 Effective Date OCT 1 1998

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State of New York**

**Staffing Summary of Personnel  
Used in the Administration of the Plan**

**New York State Department of Health**

Division of Health Care Financing	115
Division of Health Standards and Surveillance	135
Office of Medicaid Management	400
Office of Managed Care	130
Division of Administration	30
Division of Legal Affairs	15
Information Systems & Health Statistics Group	50

TN 97-15 Approval Date SEP 22 1997  
Supersedes TN 85-8 Effective Date OCT 01 1996

**OFFICE OF CONTINUING CARE**  
**DIRECTOR**  
**DEPUTY DIRECTOR**

**INFORMATION SERVICES**

- COMPUTER SYSTEMS
- DATABASES

**ADMINISTRATIVE OPERATIONS**

- BUDGETING
- PERSONNEL TRANSACTIONS
- REGULATIONS PROCESSING
- CORRESPONDENCE CONTROL

**PROGRAM DEVELOPMENT and INITIATIVES**

**QUALITY and LICENSURE**

**FINANCE and INSURANCE**

**CONTINUING CARE INITIATIVES**

- MLTC PLANS
- CCRCS

**PROGRAM DEVELOPMENT and EVALUATION**

- STRATEGIC PLANNING
- PROGRAM COORDINATION
- REGULATORY REFORM
- INTERGOVERNMENTAL RELATIONS
- CASH & COUNSELING

**PROFESSIONAL CREDENTIALING**

- NH ADM
- CNAS
- HHAS
- PC AIDES

**SURVEILLANCE and QUALITY ASSURANCE**

- SURVEY
- CERT
- Q'S

**FACILITY and PROGRAM LICENSURE**

- NHS
- HCSAS
- ADULT HOMES
- ENRICHED HOUSING

**FINANCE**

- CAPITATION RATES

**EPIC**

**PARTNERSHIP FOR LONG TERM CARE PROGRAM**

**MA PROGRAM OPERATIONS**

- PERSONAL CARE
- LTHHCP
- CHHAS
- WAIVERS
- TBI PROGRAM

**SURVEY and QUALITY ASSURANCE ACTIVITIES**

**WESTERN**

**SYRACUSE**

**NORTHEAST**

**MAR O**

TN  
 98-47  
 Approval Date FEB 13 1988

Attachment 1.2-0  
 Page 1  
 NEW YORK

New York

Executive Office

Policy and oversight for:

- Nursing Homes
- Adult Care Facilities
- Home Health Care Services
- Elderly Pharmaceutical Insurance Coverage
- Long Term Care managed Care
- Partnership for Long Term Care Insurance
- Personal Care
- Waiver Programs
- Aide Training Programs

TN 98-47 Approval Date FEB 1 6 1999  
Supersedes TN New Effective Date OCT 1 1998

New York

**Division of Program Development and Initiatives**

The Division is responsible for:

- Program Development
- Regulatory Reform
- Strategic Planning
- Intergovernmental Relations
- Cash and Counseling
- Managed Long Term Care Demonstrations
- Continuing Care Retirement Communities

TN 98-47 Approval Date FEB 1 8 1998  
Supersedes TN Now Date OCT 1 1998

New York

**Division of Quality and Licensure**

The Division is responsible for:

Licensure, Surveillance and Quality Initiatives for:

- Adult Homes
- Home Health Care Services Agencies
- Nursing Homes
- Enriched Housing Programs
- Assisted Living Programs
- Residences for Adults

Credentialing of:

- Nursing Home Administrators
- Certified Nursing Aides
- Home Health Aides
- Personal Care Aides

TN 98-47

Supersedes T.I. **New**

Approval Date FEB 18 1989

Date OCT 1 1988

New York

**Division of Finance and Insurance**

The Division is responsible for:

- Long Term Care Capitated Rates
- Elderly Pharmaceutical Insurance Coverage
- Long Term Care Partnership Plan
- Traumatic Brain Injury Program
- Personal Care
- Long Term Home Health Care Program
- Community Home Health Agency Services and Waivers

TN 98-47

Supersedes TN N3W

Approval Date FEB 1 6 1999

Date OCT 1 1998

New York

Information Services

The Bureau is responsible for:

- Network Administration
- Computer Support
- Database Administration
- Research and Evaluation Systems Activities

TN 98-47 Approval Date FEB 1 8 1999  
Supersedes TN New Issue Date OCT 1 1998

New York

Administration Services

The Bureau is responsible for:

- Budget
- Personnel
- Regulation Processing
- Correspondence Control

TN 98-47 Approval Date FEB 1 6 1998  
Supersedes TN New Effective Date OCT 1 1998

ATTACHMENT 2.1-A

A "health maintenance organization" (HMO) is defined in Section 4401 of the Public Health Law, Chapter 45 of the Consolidated Laws of the State of New York, to mean "any person, natural or corporate, or any groups of such persons who enter into an arrangement, agreement or plan or any combination of arrangements or plans which propose to provide or offer, or which do provide or offer, a comprehensive health services plan."

A "comprehensive health services plan" is defined in Section 4401 to mean "a plan through which each member of an enrolled population is entitled to receive comprehensive health services in consideration for a basic advance or periodic charge."

"Comprehensive health services" are defined in Section 4401 to mean "all those health services which an enrolled population might require in order to be maintained in good health, and shall include, but shall not be limited to, physician services (including consultant and referral services), in-patient and out-patient hospital services, diagnostic laboratory and therapeutic and diagnostic radiologic services, and emergency and preventive health services."

Section 4402 of the Public Health Law provides that "no person or groups of persons may operate a health maintenance organization or issue a contract to an enrollee for membership in a comprehensive health services plan without first obtaining a certificate of authority from the commissioner [of health]."

The Commissioner of Health may issue a certificate of authority pursuant to Section 4403 or 4403-a of the Public Health Law only if the applicant demonstrates that it has the capability of organizing, marketing, managing, promoting and operating a comprehensive health services plan, is financially responsible for the cost of providing comprehensive health services to enrollees and satisfies other conditions assuring quality of care, resolution of enrollee complaints, etc.

The HMO must make the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration and scope) as those services are to non-enrolled Medicaid recipients within the area served by the HMO.

The HMO must make provision, satisfactory to the Medicaid agency, against the risk of insolvency, and assure that Medicaid enrollees will not be liable for the HMO's debts if it does become insolvent.

TN # 86-28 Approval Date DEC 1 1989 Effective Date 1 OCT 1986  
 Supersedes  
 TN # New

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency\* Citation(s) Groups Covered

The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups

42 CFR 435.110

1. Recipients of AFDC

The approved State AFDC plan includes:

Families with an unemployed parent for the mandatory 6-month period and an optional extension of 6 months.

Pregnant women with no other eligible children.

AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

42 CFR 435.115

2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment solely because the amount would be less than \$10.

\*Agency that determines eligibility for coverage.

TN No. 91-76  
Supersedes  
TN No. 88-1

Approval Date MAR 3 1992

Effective Date OCT 1 1991

HCFA ID: 7983E

State: New York

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Agency\*      Citation(s)      Groups Covered

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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

2. Deemed Recipients of AFDC.

- 1902(a)(10)(A)(1)(I) of the Act
  - b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individuals living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.
- 402(a)(22)(A) of the Act
  - c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
- 406(h) and 1902(a)(10)(A)(1)(I) of the Act
  - d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
- 1902(a) of the Act
  - e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

\*Agency that determines eligibility for coverage.

TN No. 91-76 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
Supersedes  
TN No. 90-27 HCFA ID: 7983E

State: New York

Agency\* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

407(b), 1902  
(a)(10)(A)(i)  
and 1905(m)(1)  
of the Act

3. Qualified Family Members.

Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.

X/ Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.

1902(a)(52)  
and 1925 of  
the Act

4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

\*Agency that determines eligibility for coverage.

TN No. 91-76 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
Supersedes  
TN No. 87-49 HCFA ID: 7983E

State: New York

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.113

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:
- a. Families denied AFDC solely because of income and resources deemed to be available from--
    - (1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;
    - (2) Grandparents;
    - (3) Legal guardians; and
    - (4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);
  - b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.
  - c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

\*Agency that determines eligibility for coverage.

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TN No. 91-70 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
Supersedes  
TN No. 86-29A HCFA ID: 7983E

State: New York

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.114

6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

X Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

X Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

     Not applicable with respect to intermediate care facilities; State did or does not cover this service.

1902(a)(10)  
(A)(i)(III)  
and 1905(n) of  
the Act

7. Qualified Pregnant Women and Children.

a. A pregnant woman whose pregnancy has been medically verified who--

(1) Would be eligible for an AFDC cash payment (or who would be eligible if the State had an AFDC-unemployed parents program) if the child had been born and was living with her;

\*Agency that determines eligibility for coverage.

TN No. <u>    </u>	Approval Date <u>MAR 3 1992</u>	Effective Date <u>OCT 1 1991</u>
Supersedes		
TN No. <u>    </u>		

HCFA ID: 7983E

**NEW**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or
- (3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

1902(a)(10)(A)  
(i)(III) and  
1905(n) of the  
Act

- b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

Children born after

(specify optional earlier date)  
who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

TN No.

Supersedes

TN No.

92-27

91-76

Approval Date

JAN 20 1993

Effective Date

APR 1 - 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

COVERAGE AND CONDITIONS OF ELIGIBILITY

Groups Covered

Citation(s)

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(A)  
(I)(IV) and  
1902(1)(1)(A)  
and (B) of the Act

8. Pregnant women and infants under 1 year of age with family income up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(I)(IV) and 1902(1)(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A.

X The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.

1902(a)(10)(A)  
(I)(VI)  
1902(1)(1)(c)  
of the Act

9. Children:

a. who have attained 1 year of age but have and not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.

1902(a)(10)(A)(I)  
(II) and 1902(1)  
(1)(D) of the Act

b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

X Children born after 12/31/79  
(specify optional earlier date)  
who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for those groups are specified in Supplement 1 to ATTACHMENT 2.6A

PLAN No. 79-02

Supersedes 72-27

Approval Date JUN 29 1989

Effective Date JAN 1 1989

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

1902(a)(10)  
(A)(i)(V) and  
1905(m) of the  
Act

10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.

1902(e)(5)  
of the Act

11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.

1902(e)(6)  
of the Act

- b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

1902(e)(4)  
of the Act

12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.

42 CFR 435.120

13. Aged, Blind and Disabled Individuals Receiving Cash Assistance

X a. Individuals receiving SSI.

This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

X Aged  
X Blind  
X Disabled

TN No. 92-27

Supersedes

TN No. 91-76

Approval Date JAN 20 1993

Effective Date APR 1 - 1992

State: New York

Agency\* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

435.121

13.  b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

1619(b)(1)  
of the Act

- Aged
- Blind
- Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

\*Agency that determines eligibility for coverage.

TN No. 91-76 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
Supersedes  
TN No. 87-35A HCFA ID: 7983E



State: New York

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

- (4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
- (5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

\*Agency that determines eligibility for coverage.

TN No. 1-76 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
Supersedes  
TN No. 87-35A HCFA ID: 7983E

State: New York

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1619(b)(3)  
of the Act

The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

\*Agency that determines eligibility for coverage.

TN No. 91-76 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
Supersedes  
TN No. New HCFA ID: 7983E

State: New York

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
1634(c) of the Act		15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who-- <ul style="list-style-type: none"><li><input type="checkbox"/> a. Are at least 18 years of age;</li><li><input type="checkbox"/> b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.</li><li><input type="checkbox"/> c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.</li><li><input type="checkbox"/> d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.</li></ul>
42 CFR 435.122	16.	Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.
42 CFR 435.130	17.	Individuals receiving mandatory State supplements.

\*Agency that determines eligibility for coverage.

TN No. 91-76 Approval Date MAR 3 1991 Effective Date OCT 1 1991  
Supersedes  
TN No. New HCFA ID: 7983E

State: New York

Agency\*, Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

42 CFR 435.131

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

Aged       Blind       Disabled

Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

\*Agency that determines eligibility for coverage.

TN No. 91-26 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
Supersedes  
TN No. **New** HCFA ID: 7983E

State: New York

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

- |                |     |  |
|----------------|-----|--|
| 42 CFR 435.132 | 19. | Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--<br><br>a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and<br><br>b. Remain institutionalized; and<br><br>c. Continue to need institutional care. |
| 42 CFR 435.133 | 20. | Blind and disabled individuals who--<br><br>a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and<br><br>b. Were eligible for Medicaid in December 1973 as blind or disabled; and<br><br>c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.   |

\*Agency that determines eligibility for coverage.

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TN No. <u>-76</u>	Approval Date <u>MAR 3 1992</u>	Effective Date <u>OCT 1 1991</u>
Superseded		
TN No. <u>New</u>		HCFA ID: 7983E



State: New York

Agency\* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

42 CFR 435.135

22. Individuals who --

- a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and
- b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

\*Agency that determines eligibility for coverage.

TN No. 91-26 Approval Date MAR 1 1992 Effective Date OCT 1 1991  
Supersedes  
TN No. 87-35A HCFA ID: 7983E

State: New York

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634 of the Act

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

\*Agency that determines eligibility for coverage.

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TN No. 1-76 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
Supersedes  
TN No. 86-29A HCFA ID: 7983E

State: New York

Agency\* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634(d) of the Act

24. Disabled widows and widowers who would be eligible for SSI except for receipt of early social security disability benefits, who are not entitled to hospital insurance under Medicare Part A and who are deemed, for purposes of title XIX, to be SSI beneficiaries under section 1634(d) of the Act.

Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

Not applicable because the State applies more restrictive eligibility than those under SSI and the State chooses not to deduct any of the benefit that caused SSI/SSP ineligibility or subsequent cost-of-living increases.

The State applies more restrictive eligibility requirements than those under SSI and part or all of the amount of the benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

\*Agency that determines eligibility for coverage.

TN No. 91-76 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
Supersedes  
TN No. 91-72 HCFA ID: 7983E

OFFICIAL

State: New York

Agency	Citations(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(E)(iv)  
and 1905(p)(3)(A)(ii)  
and 1860D-14(a)(3)(D)  
of the Act \*

25. Qualified Medicare Beneficiaries—

- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
- b. Whose income does not exceed 100 percent of the Federal Poverty Level; and
- c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

(Medical Assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)

1902(a)(10)(E)(ii),  
1905(p)(3)(A)(i),  
1905(p) and  
1860D-14(a)(3)(D)  
of the Act

26. Qualified disabled and working individuals

- a. Who are entitled to hospital insurance benefits under Section 1818A of the Act;
- b. Whose income does not exceed 200 percent of the Federal poverty level

TN No. 10-15 Approval Date SEP 15 2010 Effective Date April 1, 2010  
Supersedes  
TN No. 93-27

# OFFICIAL

ATTACHMENT 2.2-A  
Page 9b1

State: New York

Agency	Citations(s)	Groups Covered
		<p>c. Whose resources do not exceed twice the maximum standard under SSI.</p> <p>d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)</p>
		<p>27. Specified Low-Income Medicare Beneficiaries—</p>
	<p>1902(a)(10)(E)(iii) 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Act</p>	<p>a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under 1818A of the Act.</p> <p>b. Whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and</p> <p>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</p> <p>(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)</p>
		<p>28. Qualified Individuals—</p>
	<p>1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act</p>	<p>a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);</p> <p>b. Whose income is at least 120 percent but less than 135 percent for the Federal poverty level;</p> <p>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</p>

TN No. 10-15

Approval Date SEP 15 2010

Effective Date April 1, 2010

Supersedes

TN No. 93-27

State: New York

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634(e) of  
the Act

28. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611(e)(3)(A) shall be treated, for purposes of title XIX, as receiving SSI benefits for the month.

\*Agency that determines eligibility for coverage.

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TN No. 95-15  
Supersedes Approval Date APR 26 1995 Effective Date FEB 10 1995  
TN No. New

State: New York

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Agency\*      Citation(s)      Groups Covered

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B. Optional Groups Other Than the Medically Needy

42 CFR  1. Individuals described below who meet the  
435.210      1902(a)      income and resource requirements of AFDC, SSI, or an  
(10)(A)(ii) and      optional State supplement as specified in 42  
1905(a) of      CFR 435.230, but who do not receive cash  
the Act      assistance.

The plan covers all individuals as described  
above.

The plan covers only the following  
group or groups of individuals:

- Aged
- Blind
- Disabled
- Caretaker relatives
- Pregnant women

42 CFR  2. Individuals who would be eligible for AFDC, SSI  
435.211      or an optional State supplement as specified in 42  
CFR 435.230, if they were not in a medical  
institution.

\*Agency that determines eligibility for coverage.

TN No. 91-4 Approval Date MAR 11 1992 Effective Date OCT 1 1991  
Supersedes New  
TN No. New HCFA ID: 7983E

State: New York

Agency*	Citation(s)	Groups Covered
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1902(a)(1)(B) and 1905(p)(3)(A)(ii) of the Act

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

27. Specified low-income Medicare beneficiaries--

- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1813A of the Act);
- b. Whose income for calendar years 1993 and 1994 exceeds the income level in 25. b., but is less than 110 percent of the Federal poverty level, and whose income for calendar years beginning 1995 is less than 120 percent of the Federal poverty level; and
- c. Whose resources do not exceed twice the maximum standard under SSI.

(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

\*Agency that determines eligibility for coverage.

TN No. 93-27  
 Supersedes NEW Approval Date SEP 14 1993 Effective Date APR 1 1993  
 TN No. NEW

Citation(s)

Groups Covered

B. Optional Groups – Other Than Medically Needy  
(Continued)

42 CFR 435.212  
& 1902(e) of the Act,  
P.L. 99-272 (section 9517)  
P.L. 101-508(section 4732)  
P.L. 105-33 (section 4708)

X 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in a Medicaid managed care organization as defined in section 1903(m)(1)(A), with a primary care case manager as defined in section 1905(l), or with an eligible organization under section 1876 of the Act, and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (not more than six months beginning on the effective date of enrollment), the State Plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum enrollment period, but, except for benefits furnished under section 1905(a)(4)(C), only with respect to such benefits provided to the individual as an enrollee of such organization or entity or by or through the case manager.

     The State elects not to guarantee eligibility.

X The State elects to guarantee eligibility. The minimum enrollment period in 6 months (not to exceed six).

The State measures the minimum enrollment period from:

     The date beginning the period of enrollment in the MCO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility.

X The date beginning the period of enrollment in the MCO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

     The date beginning the last period of enrollment in the MCO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment or of periods of enrollment as a private paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.)

TN 99-18 Approval Date FEB 10 2000  
Supersedes TN 92-01 Effective Date APR 1 1999



**B. Optional Groups Other Than the Medically Needy**  
(continued)

Citation 42 CFR 435.217

X 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver.\* The group or groups covered are listed in waiver request. This option is effective on the effective date of the State's section 1915 (c) waiver under which this group (s) is covered. In the event an existing 1915 (c) waiver is amended to cover this group (s), this option is effective on the effective date of the amendment.

\* This group of individuals includes PACE enrollees, and will be effective on the effective date of the amendment electing PACE as a State service.

TN No.:

02-01

Supersedes

TN NO.:

92-09

Approval Date

SEP 03 2002

Effective Date

JAN 01 2002

State: New York

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a)(10)  
(A)(ii)(VII)  
of the Act

5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

The State covers all individuals as described above.

The State covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

Agency that determines eligibility for coverage.

TN NO. 91-87 Approval Date MAR 11 1992 Effective Date OCT 1 1991

Supersedes

TN No. **New**

HCFA ID: 7983E

State: New York

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.220

6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

The State covers all individuals as described above.

1902(a)(10)(A)(ii) and 1905(a) of the Act

The State covers only the following group or groups of individuals:

- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

42 CFR 435.2  
1902(a)(10)(A)(ii) and  
1905(a)(i) of  
the Act

7.

a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are 21 years of age or younger as indicated below.

- 20
- 19
- 18

91-77

TN No. \_\_\_\_\_  
 Supersedes 86-29A Approval Date MAR 8 1992 Effective Date OCT 1 1991  
 TN No. \_\_\_\_\_

HCFA ID: 7983E

Revision: HCFA-PM-91-  
AUGUST 1991

(BPD)

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**OFFICIAL**

State: New York

Agency*	Citation (s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.222

b. Reasonable classifications of individuals described in (a) above, as follows:

- (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:
  - (a) In foster homes (and are under the age of 21).
  - (b) In private institutions (and are under the age of 21).
  - (c) In addition to the group under b. (1) (a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies ( and are under the age of     ).
  - (d) In the care and custody of the local social services district commissioner or who are in the care and custody of the Office of Children and Family services for the purpose of receiving foster care (and are under the age of 21).
- (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of     ).
- (3) Individuals in NFs (who are under the age of     ). NF services are provided under this plan.
- (4) In addition to the group under (b) (3), individuals in ICFs/MR (who are under the age of     ).

TN# 05-11

Approval Date: JUN 0 9 2005

Supersedes TN#: 91-77

Effective Date: JAN 0 1 2005

State: New York

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

- (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of \_\_\_\_\_). Inpatient psychiatric services for individuals under age 21 are provided under this plan.
  
- (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

91-77  
TN No. \_\_\_\_\_  
Superseded New Approval Date MAR 21 1992 Effective Date OCT 1 1991  
TN No. \_\_\_\_\_  
HCFA ID: 7983E

State: New York

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a)(10)  
(A)(ii)(VIII)  
of the Act

8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement--

- a. Was eligible for Medicaid under the State's approved Medicaid plan; or
- b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of--

<input checked="" type="checkbox"/>	21
<input type="checkbox"/>	20
<input type="checkbox"/>	19
<input type="checkbox"/>	18

TN No. 91-77  
 Supersedes TN No. 86-29A Approval Date MAR 21 1991 Effective Date OCT 1 1991  
 HCFA ID: 7983E

August 1991

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OMB No.: 0938-

State: New York

Agency*	Citation (8)	Groups Covered
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B. OPTIONAL Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.223

1902(a)(10)  
(A)(ii) and  
1905(a) of  
the Act

9. Individuals described below who would be eligible for APDC if coverage under the State's APDC plan were as broad as allowed under title IV-A:

- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

TN No.	<u>91-07</u>	Approval Date	<u>10/1/91</u>	Effective Date <u>OCT 1 1991</u>
Supersede	<b>New</b>			
TN No.				HCFA ID: 7983E

State: New York

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Agency\* Citation(s) Groups Covered

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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.230  10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in the State.
- d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.
  - (1) All aged individuals.
  - (2) All blind individuals.
  - (3) All disabled individuals.

91-77

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TN No. \_\_\_\_\_  
Supersedes \_\_\_\_\_ Approval Date \_\_\_\_\_  
TN No. 86-29A

Effective Date OCT 1 1991

HCFA ID: 7983E

State: New York

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

- |                |       |   |
|----------------|-------|---|
| 42 CFR 435.230 | — (4) | Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.                             |
|                | — (5) | Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.                            |
|                | — (6) | Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.                         |
|                | — (7) | Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
|                | — (8) | Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.     |
|                | — (9) | Individuals in additional classifications approved by the Secretary as follows:   |

91-77  
TN No. \_\_\_\_\_  
Supersedes 86-29A Approval Date MAR 11 1992 Effective Date OCT 1 1991  
TN No. \_\_\_\_\_ HCFA ID: 7983E

Revision: HCFA-PM-91-- (BPD)  
AUGUST 1991

ATTACHMENT 2.2-A  
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OMB NO.: 0938-

State: New York

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes.

No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

91-77  
TN No. \_\_\_\_\_

Supersedes \_\_\_\_\_

TN No. **New**

Approval Date

MAR 11 1992

Effective Date OCT 1 1991

HCFA ID: 7983E

State: New York

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.120  
435.121  
1902(a)(10)  
(A)(ii)(XI)  
of the Act

11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in each classification and available on a Statewide basis.
- d. Paid to one or more of the classifications of individuals listed below:
  - (1) All aged individuals.
  - (2) All blind individuals.
  - (3) All disabled individuals.

91-77

TN No. \_\_\_\_\_  
Superseded by 87-35A Approval Date \_\_\_\_\_

MAY 21 1992

Effective Date OCT 1 1991

HCFA ID: 7983E

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Agency*	Citation(s)	Groups Covered	87 35A
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1902(a)(10) (A)(ii)(IX) and 1902(l) of the Act, P.L. 99-509 (Sections 9401(a) and (b)) — 13. The following individuals who are not described in section 1902(a)(10)(A)(i) of the Act whose income level (established at an amount up to 100 percent of the Federal nonfarm poverty line) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the women and infant or child and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:

— (a) Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy) and infants under one year of age (effective April 1, 1987);

— (b) Children who have attained one year of age but not attained two years of age (effective October 1, 1987);

— (c) Children who have attained two years of age but not attained three years of age (effective October 1, 1988);

— (d) Children who have attained three years of age but not attained four years of age (effective October 1, 1989);

— (e) Children who have attained four years of age but not attained five years of age (effective October 1, 1990).

Infants and children covered under items 13(a) through (e) above who are receiving inpatient services on the date they reach the maximum age for coverage under the approved plan will continue to be eligible for inpatient services until the end of the stay for which the inpatient services are furnished.

\*Agency that determines eligibility for coverage.

TN No. 87-35A  
Supersedes  
TN No. ---

Approval Date MAR 26 1990

Effective Date JUL 01 1987

HCFA ID: 1036P/0015P

Agency\* Citation(s)

Groups Covered

87 35

The payment levels under the approved State AFDC plan are no lower than the AFDC payment levels in effect under the approved AFDC plan on April 17, 1986.

Yes.

Not applicable. The State does not provide coverage of this optional categorically needy group.

1902(a)  
(10)(A)  
(ii)(X)  
and 1902(m)  
(1) and (3)  
of the Act,  
P.L. 99-509  
(Section  
9402(a) and  
(b))

14. In addition to individuals covered under item B.13, individuals--

(a) Who are 65 years of age or older or are disabled--

As determined under section 1614(a)(3) of the Act; or

As determined under more restrictive categorical eligibility criteria specified under item A.9(b) of this Attachment.

(b) Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal nonfarm income poverty line) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

(c) Whose resources do not exceed the maximum amount allowed--

Under SSI;

Under the State's more restrictive financial criteria; or

Under the State's medically needy program as specified in ATTACHMENT 2.6-A.

\*Agency that determines eligibility for coverage.

TN No. 87-35A  
Supersedes  
TN No. ----

Approval Date MAR 26 1990

Effective Date JUL 01

HCFA ID: 1036P/O

Agency*	Citation(s)		Groups Covered	90	3
XIX	Sec 4101(a) PL 100-203 Sec 1902L (1)(A)(B) of the Act	<u>X</u> 142	The following individuals who are described in Section 1902L(1)(A)(B) of the Act whose income level (established at an amount up to 185% of the Federal non farm poverty line) specified in Supplement 1 page 2a to <u>Attachment 2.6A</u> for a family of the same size including the woman or infant under one who meet the resource standards specified in Supplement 2 to <u>Attachment 2.6A</u> .		
			(a) Woman during pregnancy (and during the 60 day period beginning on the last day of pregnancy) and infants under one year of age (effective July 1, 1988).		
			(b) The resource standard & methodology applied to the pregnant woman.		
		<u>X</u>	The State does not apply a resource standard.		
		---	The State applies a resource standard not more restrictive than SSI.		
			(c) The resources standard & methodology applied to the child under one year.		
		<u>X</u>	The State does not apply a resource standard.		
		---	The State applies a resource standard not more restrictive than AFDC.		
			(d) where the gross income of the pregnant woman or child (less child care expenses) exceeds 150% of the FPL for a family of relevant size a premium not to exceed 10% of the excess may be applied.		
		<u>X</u>	The State does not apply a premium.		
		---	The State applies a _____ percent premium.		
TN NO. <u>90-3</u>	APPROVAL DATE <u>MAY 14 1990</u>				
SUPERSEDES TN NO. <u>NEW</u>	EFFECTIVE DATE <u>JAN 01 1990</u>				

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Agency\*      Citation(s)      Groups Covered      30      3

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1902(a)(47)  
and 1920 of  
the Act,  
P.L. 99-509  
(Section  
9407)

- 15. Pregnant women who meet the applicable income levels for the categorically needy specified in this plan under ATTACHMENT 2.6-A who are determined eligible by a qualified provider during a presumptive eligibility period in accordance with section 1920 of the Act.

C. Optional Coverage of the Medically Needy

Title XIX      435.301

This plan includes the medically needy.

No.

Yes. This plan covers:

- 1. Pregnant women who, except for income and resources, would be eligible as categorically needy.

\*Agency that determines eligibility for coverage.

TH No. 90-3  
Supersedes  
TH No. 87-35A

Approval Date MAY 14 1990

Effective Date JAN 01 1990

HCFA ID: 1036P/0015P

State: New York

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

- (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
- (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
- (9) Individuals in additional classifications approved by the Secretary as follows:

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TN No. <u>91-77</u>	Approval Date <u>MAR 8 1992</u>	Effective Date <u>OCT 1 1991</u>
Supersedes		
TN No. <u>86-79A</u>		HCFA ID: 7983E

State: New York

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes

No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

91-77

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TN No.		Approval Date	MAR 1 1992	Effective Date	OCT 1 1991
Superseded					
TN No.	<b>New</b>				

HCFA ID: 7983E

State: New York

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.231   
1902(a)(10)  
(A)(ii)(V)  
of the Act

12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

The State covers all individuals as described above.

The State covers only the following group or groups of individuals:

1902(a)(10)(A)  
(ii) and 1905(a)  
of the Act

- Aged
- Blind
- Disabled
- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

91-77

TN No. 90-3 Approval Date MAR 14 1992 Effective Date OCT 1 1991  
 Supersedes 90-3  
 TN No. 90-3 HCFA ID: 7983E

State: New York

Agency Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(e)(3)  
of the Act

13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in an institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act.

Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.

1902(a)(10)  
(A)(ii)(IX)  
and 1902(l)  
of the Act

14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:

- a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and
- b. Infants under one year of age.

91-77  
TN No.

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HCFA ID: 7983E

State: New York

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a)   
(10)(A)  
(ii)(IX)  
and 1902(1)(1)  
(D) of the Act

15. The following individuals who are not mandatory categorically needy, who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in Supplement 1 of ATTACHMENT 2.6-A for a family of the same size.

Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained--

7 years of age; or

8 years of age.

91-77

TN No.

Supersedes

TN No.

91-74 Approval Date MAR 11 1992

Effective Date OCT 1 1991

HCFA ID: 7983E

State: New York

Agency\* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a)  
(ii)(X)   
and 1902(m)  
(1) and (3)  
of the Act

16. Individuals--

- a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.
- b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
- c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

91-77  
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TN No. New  
HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

state: New York

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a)(47)  
and 1920 of  
the Act

- X 17. Pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.

92-27

TN No.

Supersedes

TN No.

**New**

Approval Date JAN 20 1993

Effective Date APR 1 - 1992



State New York

Citation

Groups Covered

Optional Groups Other Than the Medically Needy

OBRA 1993  
Sec. 1902(a)(10)(A)(ii)(III)

Coverage is extended to individuals who are described in subsection (a)(1) relating to certain TB infected individuals whose income and resources are as follows:

-X-

Income (as determined under the State plan under this title with respect to disabled individuals) does not exceed the maximum amount of income of a disabled individual described in subsection (a)(10)(A)(i).

---

More liberal income disregards in accordance with section 1902(r)(2) as described in supplement 8a to Attachment 2.6A page 4 are applied.

-X-

Resources (as determined under the State plan under this title with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in section (a)(10)(A)(i) may have.

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More liberal resource disregards in accordance with section 1902(r)(2) as described in supplement 8b to Attachment 2.6A page 4 are applied.

-X-

1994-14

Approval Date JUL 1 1994

Effective Date JAN 1 - 1994

Supersedes TN No. New

Citation(s)	Groups Covered
1902(a)(10)(A) (ii)(xiv) of the act	<b>B. <u>Optional Coverage – Other Than Medically Needy</u></b> (Continued)
	<p><input checked="" type="checkbox"/> 20. Optional Targeted Low Income Children who:</p> <ul style="list-style-type: none"><li>a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spenddown liability);</li><li>b. would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on April 15, 1997 (other than because of the age expansion provided for in §1902(1)(2)(D));</li><li>c. are not covered under a group health plan or other group health insurance (as such terms are defined in §2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no federal funds for the program;</li><li>d. have family income at or below:  200 percent of the federal poverty level for the size family involved, as revised annually in the federal Register; or  A percentage of the federal poverty level, which is in excess of the "Medicaid applicable income level" (as defined in §2110(b)(4) of the Act) but no more than 50 percentage points.</li></ul> <p>The State covers:</p> <p><input checked="" type="checkbox"/> All children described above who are under age <u>19</u> (18, 19) with family income at or below <u>100</u> percent of the federal poverty level.</p>

TN 99-02 Approval Date JUN 29 1999  
Supersedes TN New Effective Date JAN 1 1999

**OFFICIAL**

State: New York

Attachment 2.2-A  
Page 23d

Citation(s) Groups Covered

**B. Optional Coverage – Other Than Medically Needy**  
(Continued)

The following reasonable classifications of children described above who are under age \_\_ (18, 19) with family income at or below the percent of the federal poverty level specified for the classifications:

(Add Narrative Descriptions(s) Of The Reasonable Classification(s) And The Percent Of The Federal Poverty Level Used To Establish Eligibility For Each Classification.)

1920A(b)(3)(A)  
of the Act

X

21. Continuous Eligibility For Children

A child under age 19 (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of 12 months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.

1920A(b)(3)(A)  
of the Act

X

22. Presumptive Eligibility For Children

Children under age 19 who are determined by a "qualified entity" (as determined in §1920(A)(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan.

The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If the application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on the last day.

TN 07-40

Approval Date JAN 16 2008

Supersedes TN 99-02 Effective Date DEC 01 2007

Citation(s)	Groups Covered
<u>B. Optional Coverage-Other Than Medically Needy</u> (Continued)	

1902 (a) (10) (A)

(ii) (XVIII) of the Act X 23. Women who:

- a. have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;
- b. are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act;
- c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and
- d. have not attained age 65.

1920B of the Act X 24. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

TN 02-18 Approval Date SEP 20 2002  
Supersedes TN New Effective Date OCT 01 2002

State/Territory: New York

Citation \_\_\_\_\_ Groups Covered \_\_\_\_\_

B. Optional Groups Other Than the Medically Needy  
(Continued)

- 1902(a)(10)(A) (ii)(XIII) of the Act            25.      BBA Work Incentives Eligibility Group – Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12 c of Attachment 2.6-A
- 1902(a)(10)(A) (ii)(XV) of the Act            26.      TWWIIA Basic Coverage Group – Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.
- 1902(a)(10)(A) (ii)(XVI) of the Act            27.      TWWIIA Medical Improvement Group – Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6-A.

NOTE: If the State elects to cover this group, it MUST also cover the basic coverage Group Described in No. 26 above.

✓ No. 03-11

Supersedes \_\_\_\_\_ Approval Date JUN 26 2003

✓ No. New

Effective Date JUL 01 2003  
HCFA ID: \_\_\_\_\_

State: New York

Agency Citation(s) Groups Covered

C. Optional Coverage of the Medically Needy

42 CFR 35.301

This plan includes the medically needy.

No.

Yes. This plan covers:

1902(e) of the Act

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.
2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902(a)(10)  
(C)(ii)(I)  
of the Act

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

91-78

TN No.

Superseded

TN No.

**New**

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MAR 11 1992

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State: New York

Agency\* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

1902(e)(4) of  
the Act

4. Newborn children born on or after  
October 1, 1984 to a woman who is eligible  
as medically needy and is receiving  
Medicaid on the date of the child's birth. The child  
is deemed to have applied and been found eligible for  
Medicaid on the date of birth and remains eligible  
for one year so long as the woman remains eligible  
and the child is a member of the woman's household.

42 CFR 435.308

5.  a. Financially eligible individuals who are not  
described in section C.3. above and who are  
under the age of--  
 21  
 20  
 19  
 18 or under age 19 who are full-time  
students in a secondary school or in the  
equivalent level of vocational or  
technical training

b. Reasonable classifications of financially  
eligible individuals under the ages of 21, 20,  
19, or 18 as specified below:

(1) Individuals for whom public agencies are  
assuming full or partial financial  
responsibility and who are:

(a) In foster homes (and are under the age  
of \_\_\_\_\_).

(b) In private institutions (and are under  
the age of \_\_\_\_\_).

91-43  
TN No.  
Superseded  
TN No.

**New**

Approval Date

MAR 11 1992

Effective Date OCT 1 1991

HCFA ID: 7983E

State: New York

Agency\* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

- (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of \_\_\_\_\_).
- (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of \_\_\_\_\_).
- (3) Individuals in NFs (who are under the age of \_\_\_\_\_). NF services are provided under this plan.
- (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of \_\_\_\_\_).
- (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of \_\_\_\_\_). Inpatient psychiatric services for individuals under age 21 are provided under this plan.
- (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

91-78

TN No.

Superseded

TN No.

**New**

Approval Date

MAR 11 1992

Effective Date OCT 1 1991

HCFA ID: 7983E

State: New York

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Agency\*      Citation(s)      Groups Covered

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C. Optional Coverage of Medically Needy (Continued)

- 42 CFR 435.310  6. Caretaker relatives.
- 42 CFR 435.320   
and 435.330 7. Aged individuals.
- 42 CFR 435.322   
and 435.330 8. Blind individuals.
- 42 CFR 435.324   
and 435.330 9. Disabled individuals.
- 42 CFR 435.326  10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
- 435.340 11. Blind and disabled individuals who:
- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;
  - b. Were eligible as medically needy in December 1973 as blind or disabled; and
  - c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

91-78

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TN No. \_\_\_\_\_  
Superseded **New** Approval Date MAR 11 1992 Effective Date OCT 1 1991  
TN No. \_\_\_\_\_  
HCFA ID: 7983E

Revision: HCFA-PM-91-8 (BPD)

October 1991

ATTACHMENT 2.2-A

Page 26a

OMB NO.: 0938-

State: New York

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Citation(s)

Groups Covered

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C. Optional Coverage of Medically Needy  
(Continued)

1906 of the  
Act

12. Individuals required to enroll in  
cost effective employer-based group  
health plans remain eligible for a minimum  
enrollment period of \_\_\_\_\_ months.

91-73

MAR 11 1992

**New**

OCT 1 1991

**Populations Which Will Be Excluded Or Exempt From Managed Care  
They Have Serious And/Or Complex Medical And/Or Emotional N**

**I. Excluded Populations**

In addition to the Medicaid eligibles previously identified, the following Medi population groups will not be eligible for enrollment under this SPA.

1. Children in State-operated psychiatric facilities and residential treatment facilities for children and youth.
2. Children who are residents of residential health care facilities at the time of enrollment and children who enter a residential health care facility subsequent to enrollment, except for short-term rehabilitative stays anticipated to be no greater than 30 days.
3. Medicaid eligible infants living with an incarcerated mother.
4. Infants weighing less than 1200 grams at birth and other infants under six months of age who meet the criteria for the SSI related category (shall not be enrolled or shall be disenrolled retroactive to date of birth).

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5. Children with access to comprehensive private health care coverage that is available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or cost-sharing amounts, when payment of such premium or cost-sharing amounts would be cost-effective, as determined by the local social services district.
6. Children expected to be eligible for Medicaid for less than six months.
7. Homeless children residing in a NYC DHS and not enrolled in a plan at the time they enter the shelter.
8. Children in receipt (at the time of enrollment) of institutional long-term care (except ICF services for the Developmentally Disabled), Long Term Home Health Care programs, Child Care Facilities, or Hospice.
9. Children receiving mental health family care services.
10. Children enrolled in the Restricted Recipient Program.

**II. Voluntary (Exempt) Populations**

There are a number of population groups that will be eligible for an exemption from mandatory enrollment. (Information on the exemption criteria and process will be

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Supersedes TN New Effective Date APR 01 2002

cluded in the enrollment materials sent to all potential eligibles. A separate pamphlet will discuss the implications and conditions of any exemptions from enrollment which are allowed). Children who fall into one of the following categories will be enrolled only on a voluntary basis:

1. **Children who are HIV+.** Once SNPs are established and certified through the milestone process, children with HIV disease must enroll in a managed care arrangement (either mainstream MCOs or SNPs). As soon as HIV SNPs are established through the milestone process in a given service area, those HIV positive children in that area who have voluntarily enrolled in mainstream MCOs will be given the option of enrolling in a SNP.
2. **Children who are diagnosed seriously emotionally disturbed (SED).** Children who have utilized 10 or more mental health visits (mental health clinic services or mental health specialty services, or a combination of these services) in the previous calendar year will be SED. Once SNPs are established and certified through the milestone process, enrollment in SNPs will remain voluntary for the SNP-eligible population, with the exception of SED children who have not selected a mental health option and are auto-assigned to a mental health SNP. These children will be mandatorily enrolled in a certified SNP for receipt of mental health services. However, a FFS option for mental health services will only be offered in counties where there is only one mental health SNP which is operated by the county.

If SNPs are not eventually established in certain areas of the State, children who would otherwise be eligible for enrollment in mental health SNPs may: (a) receive both mental health and physical benefits on a FFS basis; (b) voluntarily enroll in certified mainstream MCOs and receive the same physical and mental health services available to other Partnership Plan enrollees residing in the same service area; or (c) voluntarily enroll in certified mainstream MCOs for the provision of physical health-only services and receive mental health benefits on a FFS basis.

3. **Children for whom a managed care provider is not geographically accessible** so as to reasonably provide services. To qualify for this exemption, a person must demonstrate that no participating MCO has a provider located within thirty minutes travel time from the children's home who is accepting new patients, and that there is a fee-for-service Medicaid provider available within the thirty minutes travel time.
4. **Pregnant women who are already receiving prenatal care from a prenatal primary care provider not participating in any managed care plan** (note: this status will last through a woman's pregnancy and sixty (60) days postpartum; after that time, she will be enrolled mandatorily into an MCO if she belongs to one of the mandatory aid categories).
5. **Children with a chronic medical condition who, for at least six months, have been under active treatment with a non-participating subspecialist physician who is not a network provider for any MCO participating in the Medicaid managed care program service area.**

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Children with end stage renal disease (ESRD).

7. Children who are residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MR).
8. Children with characteristics and needs similar to those who are residents of ICF/MRs based on criteria cooperatively established by the State Office of Mental Retardation and Developmental Disabilities (OMRDD) and the NYS Department of Health (DOH).
9. Children already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of an MCO under contract for The Partnership Plan.
10. Children with a developmental or physical disability who receive services through a Medicaid Home-and-Community-Based Services waiver or Medicaid Model Waiver (care-at-home) through a Section 1915c waiver, or children having characteristics and needs similar to such children (including children on the waiting list), based on criteria cooperatively established by OMRDD and DOH.
11. Children who are residents of Alcohol and Substance Abuse Long Term Residential Treatment Programs.
12. New York City beneficiaries who are homeless and do not reside in a DHS shelter are exempt. Homeless children residing in a NYC DHS shelter and already enrolled in a plan at the time they enter the shelter may choose to remain enrolled. In areas outside of NYC, exemption of homeless children residing in the shelter system is at the discretion of the local district.
13. Children who cannot be served by a managed care provider due to a language barrier which exists when the child is not capable of effectively communicating his or her medical needs in English or a secondary language for which PCPs are available in the managed care program. Children with a language barrier still have a choice of three (3) PCPs, at least one of which is able to communicate in the primary language of the child or has a person on her/his staff capable of translating medical terminology, and the other two (2) PCPs have access to the AT&T Language Line as an alternative to communicating directly with the child in his/her language. Children will be eligible for an exemption when:
  - The child has established a relationship with a primary care provider who has the language capability to serve the child and who does not participate in any of the managed care plans available within a thirty minute/thirty mile radius of the child's residence.
  - Neither fee-for-service nor the above described three (3) participating PCPs are available within the thirty minute/thirty mile radius, and a fee-for-service provider with the language capability to serve the child is available outside the thirty minute/thirty mile radius and the above-described three (3) participating PCPs are not available within that radius.

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14. **Children with a County of Fiscal Responsibility code of 98 (OMRDD in MMIS) will be exempt until the State establishes appropriate program features. Recipients with a code of 97 (OMH in MMIS) will be mandatorily enrolled when the state establishes appropriate program features. However, many of these children will qualify for other exemptions (SED) or exclusions.**
15. **Children temporarily residing out of district, (e.g., college students) will be exempt until such time as the purpose of the absence is accomplished. The definition of temporary absence is set forth in Social Services regulations at Title 18 Section 360-1.4(p). These children will have difficulty accessing services within travel time and distance standards.**

**Note: Any exemption granted to children with chronic medical conditions being treated by a non-participating sub-specialist physician or those scheduled for major surgical procedures prior to enrollment with a provider outside the MCO network will apply only until such time as the child's course of treatment is completed. Such exemptions must be renewed annually. The treating physician will determine when a child's course of treatment is completed. However, if the child's treating physician subsequently becomes a network provider for one of the participating MCOs the exemption will no longer apply.**

**Determination of a child's eligibility for exemption will be conducted by the local districts upon the request of the individual or his/her designee. Local districts (or the broker) will follow state guidelines in determining eligibility for exemption. When exemption status is unclear, the district may request assistance from the SDOH Office of Managed Care.**

**Children may request an exemption to enrollment in an MCO. Children eligible for an exemption who choose to enroll in managed care will be treated as voluntary enrollees for purposes of disenrollment provisions. Accordingly, these children may disenroll from an MCO with thirty days notice and return to the fee-for-service program.**

**Children who become eligible for exemption due to a change in eligibility status after they have enrolled in managed care may apply for exemption and be disenrolled within 30-60 days. All managed care enrollees will have received information on the exemption criteria and process in the enrollment kits.**

### **III. Other Children with Unusually Severe Chronic Care or Complex Referral Needs**

**The SDOH Medical Director for Managed Care will, upon the request of an enrollee or his/her guardian, review for a possible exemption from mandatory enrollment in managed care cases of children with unusually severe chronic care needs if such children are not otherwise eligible for an exemption (i.e., meet one of the criteria listed in the previous section). The Medical Director may also authorize disenrollment for such children.**

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## IDENTIFICATION OF CHILDREN TO BE EXCLUDED OR EXEMPT WHO HAVE SERIOUS AND/OR COMPLEX MEDICAL AND EMOTIONAL NEEDS

The local social services districts (LDSS) in New York State will assume primary responsibility for the enrollment process under this State Plan Amendment. Under the existing Medicaid program, each LDSS is responsible for the determination of Medicaid eligibility. LDSS operations, including policies and staffing, will be enhanced to accommodate the new program established under this SPA. LDSS responsibilities (with assistance from SDOH) will include identification of excluded and exempt populations, including the handling of exemption requests.

Children may be either excluded or exempted from mandatory participation. Excluded populations will not participate; exempt populations are not required to participate. However, children designated as exempt may elect to voluntarily enroll.

In some cases, the State and LDSS can identify exempt populations through existing claims and eligibility data. Some excluded populations can be identified through the eligibility system. The State and/or LDSS will append the eligibility records with an identifier that will enable the Enrollment and Benefits Counselor or the Local District to determine whether a child is exempt from mandatory participation. In cases where the State can determine in advance a child's exempt status the system will flag this child's eligibility files to prevent an auto-assignment from taking place. However, in the case of children who may be exempt, but cannot be identified in advance and certain children actually eligible for an exemption in other categories), the algorithm will assign these children to an MCO unless they actually apply for and receive an exemption from the LDSS.

Children who are identified as exempt through analysis of existing aid category or through claims data will not receive a notice indicating that the State has found them to be exempt from mandatory participation. Exempt children will be informed of their option to enroll in an MCO or be waived from mandatory participation. These children will be receiving the same enrollment package as others being recertified or applying for assistance. This package includes information on exemptions and who is eligible. However, the recipient's case will be electronically flagged as exempt which will prevent auto-assignment. Exempt children so flagged will not receive a reminder notice regarding the requirement to enroll in a MCO. If the recipient chooses to enroll in an MCO, the worker inputting the enrollment information will get a computer message that alerts him/her that an exemption code is on file, and if the client chooses to disenroll at a later date, will not be auto-assigned as long as that exemption code remains.

In certain cases, the State and LDSS may lack the information necessary to determine in advance whether the child is exempt from participation. Accordingly, the State has developed an exemption application to enable such children to apply for exemption from participation. The LDSS will collect and process applications for exemption from mandatory participation. The exemption application forms and criteria for approving or

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denying requests shall be provided by the State to the LDSS. Exemption forms, including the look-alike screening form, are available to beneficiaries through the LDSS.

Eligible enrollees may apply for an exemption at any time. However, if the child is enrolled already in an MCO, s/he may be required to access services through the MCO until the LDSS and State have had the opportunity to process the application and disenroll the child from an MCO.

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SPA County Participation

Counties with 2 MCOs*	Counties with 1 MCO in Rural Areas*	Counties with no MCOs or 1 MCO in Urban Areas
Albany	Cortland	Allegany
Broome	Delaware	Cayuga
Cattaraugus	Fulton	Chemung
Chautauqua	Genesee	Chenango
Columbia	Herkimer	Clinton
Erie	Montgomery	Dutchess
Greene	Otsego	Essex
Livingston	Putnam	Franklin
Monroe	Schenectady	Hamilton
Nassau	Schoharie	Jefferson
Niagara	Seneca	Lewis
Oneida	Sullivan	Madison
Ontario	Tioga	St. Lawrence
Onondaga	Ulster	Schuyler
Orange	Warren	Steuben
Orleans	Yates	Tompkins
Oswego		Wyoming
Rensselaer		
Rockland		
Saratoga		
Suffolk		
Westchester		
Washington		
Wayne		
New York City		

\* These counties will be participating as mandatory Medicaid managed care counties under this SPA.

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**Rural Area Residents**

For recipients who reside in a rural area with a single MCO, the State will limit enrollment to such MCO, provided however, such recipient may:

1. Choose from at least two physicians or case managers; and
2. Obtain services from any other provider under the following circumstances:
  - (a) The service or type of provider is not available within the MCO network.
  - (b) The provider is not part of the MCO network, but has an existing relationship with the recipient.
  - (c) The only plan or provider available to the recipient does not, because of moral or religious objections, provide the service the enrollee seeks.
  - (d) The State determines that other circumstances warrant out-of-network treatment.

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## Methodology and Process For Capacity/Network Analysis

A managed care organization (MCO) provider network consists of physicians, group(s) of physicians, specialists and the service centers, i.e., hospitals, pharmacy, clinics, etc. that are contracted to the MCO to provide all of the health care services that may be required by enrollees. The MCO, through its provider network, must plan, direct, coordinate, and provide for the health care services of every enrollee.

The New York State Department of Health (SDOH), in conjunction with the Local Departments of Social Services (LDSS) and the New York City Office of Medicaid Managed Care (OMMC) will evaluate the provider networks of every MCO to determine that it has an adequate network that will be accessible to all enrollees for their health care needs. This review ensures that the MCO has the adequate capacity in its provider network to meet the needs of the target population and there is an adequate network structure.

To serve the Medicaid population in New York State, an MCO must successfully complete the Certification of Authority (COA) process. Review and evaluation of the provider network are essential components of the Certification process since the inception of Article 44 of the Public Health Law.

MCO network evaluation is a multi-step process. To qualify, a MCO network has to achieve a successful quantitative score assigned by SDOH using a Statistical Analysis Software (SAS) program. Then the network has to pass the scrutiny of the LDSS, which evaluates the network for compliance with time and distance standards. The third and final step is verification of the network during the Readiness Review conducted by SDOH Area Office staff just prior to an MCO becoming operational. During the Readiness Review site visits contracts are pulled to verify the network information submitted by the MCO.

The following discussion provides the necessary information to understand how SDOH calculates and monitors Medicaid MCO capacity on an on-going basis.

### A. Network Adequacy Definition

Pursuant to Section 98.5(b)(9) of Title 10, NYCRR, each fully capitated MCO is required to provide:

"Identification of the type of HMO that is proposed and a description of the service delivery system of the proposed HMO, including the numbers and locations of primary care providers and providers of other services such as ambulatory, ancillary and hospital services; ..."

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In addition, pursuant to Section 98.16(a) of Title 10, NYCRR, MCOs must submit an annual listing of providers and facilities by location. Section 364-j(8)(f) & (g) of the Social Services Law requires:

(f) Every managed care provider shall ensure that the provider maintains a network of health care providers adequate to meet the comprehensive health needs of its participants and to provide an appropriate choice of providers sufficient to provide the services to its participants by determining that:

- (i) there are a sufficient number of geographically accessible participating providers;
- (ii) there are opportunities to select from at least three primary care providers; and
- (iii) there are sufficient providers in each area of specialty practice to meet the needs of the enrolled population.

(g) The commissioner of health shall establish standards to ensure that managed care providers have sufficient capacity to meet the needs of their enrollees, which shall include patient to provider ratios, travel and distance standards and appropriate waiting times for appointments.

### 1. Providers and Service Centers

The MCO provider network must include providers for services included in a core benefit package (listed below) which is required for certification. If the MCO does not directly provide such services, contractual relationships with appropriately qualified providers must exist prior to certification. In addition to the core providers, the network must contain any other providers necessary to provide all the health care services included in the benefit package. If, for example, the MCO covers podiatry services, the network must contain a podiatrist in each service area. The following lists the core group of providers and services required for certification.

#### Medicaid Core Benefit Package

<u>Provider File:</u>	<u>Provider File:</u>	<u>Service/Ancillary File:</u>	<u>Service/Ancillary File or Provider File:</u>
<u>Primary Care</u>	<u>Specialty Care</u>	<u>Ancillary/Tertiary Care</u>	<u>Specialty Care</u>
<u>Family Practice</u>	<u>Allergy/Immunology</u>	<u>Ambulance</u>	<u>Anesthesiology</u>
<u>General Practice</u>	<u>Cardiology</u>	<u>Durable Medical Equipment</u>	<u>Audiology</u>
<u>Internal Medicine</u>	<u>Dermatology</u>	<u>Home Health Care</u>	<u>Infectious Disease</u>
<u>Pediatrics</u>	<u>Gastroenterology</u>	<u>Hospitals</u>	<u>Radiology</u>
<u>OB/GYN as PCP</u>	<u>General Surgery</u>	<u>Medical Laboratories</u>	<u>Optometry</u>

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Nurse	Geriatrics	Pharmacies	Pathology
Nurse Practitioner	Nephrology	Alcohol and Chemical Dependency Inpatient and Outpatient	Social Work
	Neurology	Mental Health Inpatient and Outpatient	Therapy : Physical
	Obstetric/Gynecology		Therapy : Speech/Language
	Oncology/Hematology		Therapy : Occupational
	Optometry		
	Ophthalmology		
	Orthopedics		
	Otolaryngology (ENT)		
	Psychiatry		
	Psychology		
	Podiatry		
	Pulmonary Medicine		
	Urology		
		Dentistry**	

\*\*=Optional benefit, not a mandatory benefit

## 2. Network Adequacy Determination

The Bureau of Certification and Surveillance within SDOH is responsible for assessing the adequacy of the network. While obstetricians, gynecologists and certified nurse mid-wives are not generally considered primary care providers, these specialties may be included with the Primary Care Physician (PCP) grouping because they may act as a PCP if they have met SDOH qualifications. Part of the adequacy determination is evaluating whether the MCO has a sufficient number of PCPs to allow the member to have choice.

### B. Network Capacity Definition

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Most often, the capacity of a provider may depend on the efficiency of the doctor and her associated staff. Capacity may be defined as either a member-to-provider ratio or a maximum number of enrollees a primary care provider can properly handle on a full time basis (i.e., 40 hrs/week). The SDOH is using a combination of these two definitions. SDOH is using the following definition of capacity.

"MCOs must adhere to the member-to-PCP ratios shown below. These ratios are for Medicaid members only, are MCO-specific, and assume that the practitioner is an FTE (practices 40 hours per week for the MCO):

- No more than 1,500 Medicaid members for each physician, or 2,400 for a physician practicing in combination with a physician assistant. (i.e., a physician extender adds 900 to physician capacity)
- No more than 1,000 Medicaid members for each nurse practitioner. (RFP, p.34)"

The above ratios are used as an initial starting point for the analysis of capacity.

Additionally, SDOH uses the following additional criteria for Article 28 comprehensive community-based primary care provider centers and Outpatient Departments of Hospitals (OPDs).

- Individual providers practicing in Article 28 Comprehensive Community based Primary Care centers may have 3,000 enrollees: 1 PCP and practicing with a Physician Extender they may have 4,000 enrollees: 1 PCP with a physician extender
- Individual providers with practices based primarily in OPDs may have 2,500 enrollees: 1 PCP and practicing with a Year 2 or 3 resident they may have 4,000 enrollees: 1 PCP & FTE Resident.

### C. Capacity Calculation and Process

It is important to recognize that there are technically two types of capacity reviewed by the SDOH for each MCO: potential capacity and financial capacity. Potential capacity refers to the number of enrollees that can be managed by the existing provider network. Financial capacity is defined as the capacity that is financial feasible for the MCO to pay for based on their available capital and escrow deposit reserve requirement.

The following discussion details how the potential capacity is calculated; thus, the term capacity in the following section refers to the potential or calculated network capacity. Throughout the process of examining capacity it is also important to note that the value placed on capacity or the number of enrollees that a PCP may serve greatly controls the outcome of the capacity algorithm.

#### 1. Potential Provider Capacity

The first step in calculating capacity for a MCO is the collection of data. SDOH collects network data electronically on an intranet system referred to as the Health Provider

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Network (HPN). This system was established in winter, 1996 for SDOH to collect information electronically from the MCOs. The MCOs are connected to the SDOH by a modem on their personal computer, they submit the data electronically in a specified format, the data is then edited immediately and a report is sent back to the MCOs with the number of records accepted along with an explanation of the records with errors. The steps below outline the methodology created for the entire provider network calculation of capacity.

- Health Provider Network
  - a. Elimination of incomplete or incorrect data
  - b. Electronic edit program
- Capacity Program
  - a. Matching to Physician License Master File
  - b. PCP Calculated Capacity based on FTE
  - c. PCP Calculated Capacity within and across MCOs
  - d. Capacity for each county

**a. Health Provider Network (HPN) Process**

As described above, all of the MCOs are required to submit provider network information on the SDOH's intranet system called the Health Provider Network (HPN). The details for submitting the provider network information are outlined in the *Data Dictionary for Managed Care Provider Network*. There are two files that are sent electronically to the SDOH, a provider file on people or physicians and other providers that are contacted to provide services to the members and a service file on places that are contacted with the MCO. Only the provider file is the used for the capacity calculation.

**I. Elimination of Incomplete Data**

Each submitted provider network record must contain certain data elements which, if omitted, will result in the deletion of a provider record. The required data elements are listed below:

- Last Name
- First Name
- License Number
- County Code
- Address (Street, Town/City)
- Board Status
- Primary Specialty
- Provider Type
- Primary Designation
- Residency Status
- Physician Status
- Panel Status

Data Elements for Primary Care Providers (PCPs) Only- all office hours

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If any of these data elements are missing or incorrectly coded by the MCO, it will receive an error message for the record(s) containing the missing element.

## ii. Electronic Edit Program

The edit program on the HPN currently checks for 46 different errors on the provider file; 20 of these are classified as critical or "hard" errors; the remaining errors are referred to as soft errors. MCOs are required to pass all critical errors for the data submission to be acceptable for use in any analysis. If they have not passed critical errors on the day after the submission is due (it is due 15 business days after the end of the calendar quarter) then the MCO is sent a letter requesting that their submission be corrected.

## 2. Capacity Program

The capacity program was developed using the SAS programming language. The quarterly provider file from the HPN and the physician master file from the NYS Department of Education are the two data sets used in the program. A Primary Care Provider or PCP subset of the Provider File data file is created for New York State providers indicated to be a Medicaid Primary Care Provider.

(Primary Care Providers are identified by editing the primary designation (PRIMDESG) and primary specialty (PRIMSPEC) fields; i.e., PRIMDESG values must equal 1=PCP and/ or 3=PCP and Specialist AND PRIMSPEC values must equal 050' (Family Practice), 060' (Internal Medicine), 182' or 776' (General Practice), 150' (General Pediatrics) OR 089', 159', 169', (OB/GYN providers) (OB/GYN are subject to DOH qualifications). The STATE data field must equal NY.

### a.) Matching to the Physician License Master File

The first step involves a match of the physician/provider license number on the HPN provider file to the NYS Education file. This is to verify that the physicians on the HPN are currently licensed and registered to practice. During this step a variable is created on each data file to define each individual provider; this variable is created by the concatenation of the last three digits in the provider's last name and their license number. The records that match on both the HPN provider file and the education file are then stored in a data set, called PCPCAP, to be used for the remainder of the capacity program.

### b.) PCP Capacity for Each Individual Provider

The next steps involve the calculation of capacity for each individual PCP using the member-to-provider ratios previously described. Several new variables are created within the PCPCAP data set for use in the capacity program. There are:

TOTOFFHR (Total Office Hours). This represents the sum of all available office hours. The maximum office hours attributed to an individual provider is 40. If the provider's total office hours across MCOs and sites exceeds 40, the hours

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at each site and MCO are reduced and allocated to each site on a prorated basis.

UNIQSITE (each providers location for each MCO). This variable accounts for the unique MCO and location for each provider and is constructed by concatenating the MCO identifier, provider license number and location address (site name, street number, room number, and street name). Many IPA and network model MCOs have overlapping provider networks, thus many of the providers are not unique to a particular MCO. (Usually, providers belonging to a staff or group model MCOs are unique to one program). To determine the effect of this on the capacity for each MCO, this field was created to capture the unique capacity that each MCO is offering.

TOTMPANL (Total Medicaid Panel Size). This is the sum of the total Medicaid panel or the total of the capitated enrollees that are recorded for a particular provider in each MCO. This will sum the panel size for all Medicaid MCOs.

FTE (Full Time Equivalent). TOTOFFHR are used to create a Full time equivalent or FTE based upon 40 hours per week. This is done by examining the multiple sites that a provider may have within an MCO and the multiple number of MCOs that a provider may belong to, i.e., a provider may be contracted in more than one MCO.

Only PCPs with TOTOFFHR (total office hours) equaling 16 hours or more per location are selected; this criteria is modified for residents; second year resident physicians must practice at least (8) continuity of care hours per week at a primary site; third and fourth year residents must practice at least twelve (12) continuity of care hours per week at a primary site. If a provider's total office hours at a particular site is below program minimum standards, his/her record is deleted.

The remaining steps calculate the PCP capacity for each provider. Specifically, the remaining steps are:

- For non-medical resident physicians practicing alone, capacity will be set equal to the lesser of : actual capacity reported or 1,500 \* FTE

Under this formula, a physician practicing full time would have a maximum capacity of  $1,500 \cdot 40/40 = 1,500$ .

- For PGY2 medical residents physicians, as denoted by 2° in the Resident Status filed, capacity will be set equal to the lesser of : actual capacity reported or 750 \* FTE
- For PGY3 medical residents physicians, as denoted by 3° in the Resident Status filed, capacity will be set equal to the lesser of : actual capacity reported or 1,125 \* FTE
- For PGY4 medical residents physicians, as denoted by 4° in the Resident Status filed, capacity will be set equal to the

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lesser of : actual capacity reported or 1,500 ° FTE

- For nurse practitioners and certified midwives, capacity will be set equal to the lesser of : actual capacity reported or 1,500 ° FTE
- The sum of the Medicaid panel size for every MCO that a provider identified is then subtracted from the potential capacity for only those physicians having an open panel.
- Physicians that have a closed panel for any MCO are assigned the Medicaid panel size for their capacity.

### c.) Capacity Calculation Within And Across MCOs

After the above calculations are made, the program can identify providers if they practiced in multiple MCOs. For those providers, the total reported office hours across sites are summed and compared against a maximum of 40 hours. If the total exceeded 40 hours, the hours at each site and MCO were prorated down and the capacity at each MCO also is prorated accordingly. For example, if a provider reported working 40 hours at MCO A and 40 hours at MCO B (80 hours in total), and reported a capacity of 1,500 at each site, the provider's capacity was reset to equal 750 at each site. She would be counted as a .5 FTE for each MCO.

The next step in the capacity program summarizes the adjusted provider-specific capacity for each MCO. The summation of all the capacity values for each of the individual PCPs determines the MCO's total capacity.

### d.) Capacity for Each County

The final step in the capacity program produces the capacity for all MCO and county combinations; the county service area is based on the geographic border of the location of the physicians within the county borders

## C. Financial Capacity

In addition to the worksheets on provider network information, MCOs are also asked to provide Revenue and Expense and enrollment projections. These are statements detailing the capacity that could be supported by their financial reserves and capital.

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#### D. Borough/County Network Analysis

New York City and the individual counties also will evaluate provider networks. The City and counties are sent a Network Composition proposal for each of the MCOs proposing for contract. They then were responsible for assembling local review teams to examine the proposals and complete a County Network Evaluation Form. (Training has been provided to City and county evaluators to ensure that proposals were reviewed in a consistent manner across the State.)

The Borough/County Network form was designed to supplement the information captured through the State Network Evaluation, by asking New York City and the other LDSS to:

- verify that the distribution of providers re: travel time/distance standards for PCPs, hospitals, and pharmacies;
- verify that networks include all providers with whom the county is mandating MCOs to contract (i.e., public hospitals), and
- document any gaps in service area coverage that the must be filled pursuant to awarding a contract.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER  
THE AGE OF 21, 20, 19, AND 18

01-80  
TN No. 01-80 Approval Date FEB 3 1992 Effective Date OCT 01 1991  
Supersedes 85-25  
TN No. 85-25 HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

Method for Determining Cost Effectiveness of Caring for  
Certain Disabled Children At Home

TN No. 01-50  
Supersedes New Approval Date FEB 3 1992 Effective Date OCT 01 1991  
TN No. New HCFA ID: 7983E

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Supplement 1 to Attachment 2.6-A

Page 1

OMB No. 0938-

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State: New York

**INCOME ELIGIBILITY LEVELS**

**A. Mandatory Categorically Needy**

1. AFDC-Related Groups other than Poverty Level Pregnant Women and Infants: Eligibility for these groups is based on the monthly standard of need (SON) as reflected in the Title IV-A State Plan approved as of July 16, 1996. The monthly SON equals the payment standard. The following illustrates how the SON is derived:

For a household of three living in Suffolk County, and paying for Public Service Commission (PSC) electric heat, the family is allowed: a basic allowance of \$238, which is intended to be used for food, clothes, personal incidentals, etc.; a Home Energy Allowance of \$30; a Supplemental Home Energy Allowance of \$23; a Shelter Allowance of \$387; and a Fuel Allowance for PSC electric heat of \$90. The total monthly SON for a family of 3 living in Suffolk County is \$768.

Additional items of need as described on page 1 of Attachment E, "Standard of Need" for the July 16, 1996 Title IV-A State Plan, in Section 352.1, paragraph (c) are also provided as circumstances warrant. The SON/payment standard would then increase accordingly.

2. Pregnant Women and Infants under Section 1902(a) (10) (i)(A) (IV) of the Act:

Effective April 1, 1990, based on the following percent of the official Federal income poverty level--

133 Percent                      185 Percent (No more than 185 percent)  
 [(Specifically)] (as revised annually in the  
 Federal Register for the size family involved.)

<u>Family Sizes</u>	<u>Income Level</u>
[ <u>1</u> ]	\$17,224
[ <u>2</u> ]	\$23,107
[ <u>3</u> ]	\$28,990
[ <u>4</u> ]	\$34,873
[ <u>5</u> ]	\$40,756

Note: A State Plan amendment was approved under Section 1902 (r) (2) to allow for a disregard of income between 185% and 200% of the poverty level for pregnant women and infants.

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**Attachment E  
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**STANDARD OF NEED**

**Section 352.1 Standard of need for determining eligibility.**

The eligibility for public assistance of all persons who constitute or are members of a family household must be determined by a social services district by applying the following statewide standard of monthly need which must consist of:

(a) regular recurring monthly needs, exclusive of shelter, fuel for heating, home energy payments and supplemental home energy payments, in accordance with the following schedule:

**SCHEDULE SA-1  
STATEWIDE STANDARD OF NEED  
Number of persons in household  
Each additional**

One	Two	Three	Four	Five	Six	Person
\$112	\$179	\$238	\$307	\$379	\$438	\$60

(b) plus the amount of money for shelter, fuel for heating, home energy payments and supplemental home energy payments, required monthly for such persons in accordance with provisions of law and department regulations; and

(c) for any of such persons who may because of their case circumstances require any of the following items in accordance with applicable provisions of law and department regulations, the standard of need must include the cost of the required item or items in accordance with such provisions: furniture and furnishings for the establishment of a home, essential repair of heating equipment, cooking stoves and refrigerators, additional cost of meals for persons unable to prepare meals at home, replacement of clothing or furniture which has been lost in a fire, flood or other like catastrophe, cost of services and supplies already received, miscellaneous shelter costs, day care, camp fees and payment of life insurance premiums.

**352.2 Allowances and grants for persons who constitute or are members of a family household.**

(a) Each social services district must utilize the applicable schedules of monthly grants and allowances as found in subdivision (d) of this section to provide for all items of need, exclusive of:

- (1) shelter;
- (2) fuel for heating;

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*New*

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- (3) additional cost of meals for persons who are unable to prepare meals at home;
- (4) purchase of necessary and essential furniture required for the establishment of a home;
- (5) replacement of necessary furniture and clothing for persons in need of public assistance who have suffered the loss of such items as the result of fire, flood, or other like catastrophe;
- (6) essential repair of heating equipment, cooking stoves and refrigerators;
- (7) allowances for occupational training; and
- (8) other items for which specific provision is otherwise made in this Part.

(b) For the purposes of such monthly grants and allowances under Family Assistance or Emergency Assistance to Needy Families with Children, children or adults residing with an SSI beneficiary must be considered as a separate household from the SSI beneficiary.

(c) Supplemental allowances and grants may not be made other than as authorized under the regulations nor in excess of established schedules. In no event, except as provided in Part 397 of this Title, must a special allowance and grant be required to be made because the cash has been lost, stolen or mismanaged. Any duplicate allowance and grant made for such purpose is not reimbursable by the State unless made as a result of an order made after May 1, 1977 by a court of competent jurisdiction or a payment made after May 1, 1977 pursuant to an order by a court of competent jurisdiction.

(d) The monthly grants and allowances must be as follows:

**SCHEDULE SA-2a**  
**STATEWIDE MONTHLY GRANTS AND ALLOWANCES,**  
**EXCLUSIVE OF HOME ENERGY PAYMENTS AND**  
**SUPPLEMENTAL HOME ENERGY PAYMENTS**  
**FOR SNA-VA-FA**  
 Number of persons in household

						Each additional person
One	Two	Three	Four	Five	Six	
\$112	\$179	\$238	\$307	\$379	\$438	\$60

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**SCHEDULE SA-2b  
STATEWIDE MONTHLY HOME ENERGY PAYMENTS  
FOR SNA-VA-FA**

Number of persons in household

One	Two	Three	Four	Five	Six	Each additional person
\$14.10	\$22.50	\$30.00	\$38.70	\$47.70	\$55.20	\$7.50

**SCHEDULE SA-2c  
STATEWIDE MONTHLY SUPPLEMENTAL HOME ENERGY  
PAYMENTS FOR SNA-VA-FA**

Number of persons in household

One	Two	Three	Four	Five	Six	Each additional person
\$11	\$17	\$23	\$30	\$37	\$42	\$5

(e) Provision of home energy assistance payments set forth in subdivision (d) of this section must be effective for grants made on or after July 1, 1981.

(f) Provision of supplemental home energy assistance payments set forth in subdivision (d) of this section must be effective for grants made on or after January 1, 1986.

**352.3 Rent allowances.**

(a) Each social services district must provide a monthly allowance for rent in the amount actually paid, but not in excess of the appropriate maximum of such district for each family size, in accordance with the following schedules:

**LOCAL AGENCY MAXIMUM MONTHLY SHELTER ALLOWANCES  
WITHOUT HEAT**

	By family size							
	1	2	3	4	5	6	7	8+
Albany	176	204	234	255	276	285	297	325
Allegany	143	165	190	207	224	232	241	264
Broome	170	197	227	247	268	277	288	316
Cattaraugus	143	165	190	207	224	232	241	264
Cayuga	160	185	213	232	251	260	271	296

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Chautauqua	145	168	193	210	228	235	245	268
Chemung	155	179	206	225	243	251	262	286
Chenango	142	164	189	206	223	231	240	263
Clinton	137	159	183	199	216	223	232	254
Columbia	155	180	207	226	244	253	263	288
Cortland	179	208	239	261	282	292	304	332
Delaware	151	175	201	219	237	245	255	279
Dutchess	174	202	232	253	274	283	295	322
Erie	155	182	205	223	242	250	260	285
Essex	145	168	193	210	228	235	245	268
Franklin	128	145	167	182	197	204	212	232
Fulton	125	145	167	182	197	204	212	232
Genesee	160	185	213	232	251	260	271	296
Greene	155	180	207	226	244	253	263	288
Hamilton	145	168	193	210	228	235	245	268
Herkimer	125	145	167	182	197	204	212	232
Jefferson	187	217	249	271	294	304	316	346
Lewis	105	122	140	153	165	171	178	195
Livingston	158	183	210	229	248	256	267	292
Madison	152	176	202	220	238	246	257	281
Monroe	227	263	302	329	356	368	384	420
Montgomery	125	145	167	182	197	204	212	232
Nassau	270	313	360	392	425	439	472	503
New York City	207	240	276	301	326	337	356	384
Niagara	163	189	217	237	256	265	276	302
Oneida	131	152	175	191	207	214	222	243
Onondaga	185	214	246	268	290	300	312	342
Ontario	165	191	220	240	260	268	279	306
Orange	195	226	260	283	307	317	330	361
Orleans	160	185	213	232	251	260	271	296
Oswego	141	164	188	205	222	229	239	261
Otsego	153	177	204	222	241	249	259	284
Putnam	195	226	260	283	307	317	330	361
Rensselaer	134	157	164	179	194	200	208	228
Rockland	272	316	363	396	428	443	461	505
St. Lawrence	134	156	179	195	211	218	227	249
Saratoga	164	190	218	238	257	266	277	303
Schenectady	168	195	224	244	264	273	284	311
Schoharie	153	177	204	222	241	249	259	284
Schuyler	149	172	198	216	234	242	251	275

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Seneca	162	188	216	235	255	264	274	300
Steuben	137	159	183	199	216	223	232	254
Suffolk	290	337	387	422	457	472	491	538
Sullivan	164	190	218	238	257	266	277	303
Tompkins	163	189	217	237	256	265	276	302
Tioga	190	220	253	276	299	309	321	352
Ulster	221	256	294	320	347	359	373	409
Warren	159	184	212	231	250	259	269	295
Washington	168	195	224	244	264	273	284	311
Wayne	165	191	220	240	260	268	279	306
Westchester	259	300	345	376	407	421	438	480
Wyoming	155	179	206	225	243	251	262	286
Yates	139	161	185	202	218	226	235	257

LOCAL AGENCY MAXIMUM MONTHLY SHELTER ALLOWANCES  
WITH HEAT

	By family size							
	1	2	3	4	5	6	7	8+
Albany	184	213	245	267	289	299	311	341
Allegany	190	220	253	276	299	309	321	352
Broome	218	252	290	316	342	354	368	403
Cattaraugus	179	208	239	261	282	292	304	332
Cayuga	179	208	239	261	282	292	304	332
Chautauqua	167	194	223	243	263	272	283	310
Chemung	197	228	262	286	309	320	333	364
Chenango	189	219	252	275	297	307	320	350
Clinton	156	181	208	227	245	254	264	289
Columbia	191	221	254	277	300	310	323	353
Cortland	199	231	265	289	313	323	337	368
Delaware	200	232	267	291	315	326	339	371
Dutchess	216	251	288	314	340	351	366	400
Erie	169	201	215	234	254	262	273	299
Essex	199	231	265	289	313	323	337	368
Franklin	161	191	212	239	250	259	269	295
Fulton	159	184	212	231	250	259	269	295
Genesee	202	234	269	293	317	328	342	374
Greene	197	229	263	287	310	321	334	366
Hamilton	159	184	212	231	250	259	271	296
Herkimer	173	200	230	251	271	281	292	320
Jefferson	200	232	267	291	315	326	339	371

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Lewis	152	177	203	221	240	248	258	282
Livingston	187	217	249	271	294	304	316	346
Madison	199	231	265	289	313	323	337	368
Monroe	257	298	343	374	405	418	436	477
Montgomery	158	184	211	230	249	257	268	293
Nassau	288	334	384	419	453	468	527	561
New York City	215	250	286	312	337	349	403	421
Niagara	174	202	232	253	274	283	295	322
Oneida	179	207	238	259	281	290	302	331
Onondaga	203	235	270	294	319	329	343	375
Ontario	207	240	276	301	326	337	351	384
Orange	229	265	305	332	360	372	387	424
Orleans	202	234	269	293	317	328	342	374
Oswego	183	212	244	266	288	298	310	339
Otsego	200	232	267	291	315	326	339	371
Putnam	237	275	316	344	373	386	401	439
Rensselaer	153	179	193	210	228	235	245	268
Rockland	302	350	402	438	474	490	511	559
St. Lawrence	182	211	242	264	286	295	307	336
Saratoga	185	215	247	269	291	301	314	343
Schenectady	195	226	260	283	307	317	330	361
Schoharie	199	231	265	289	313	323	337	368
Schuyler	194	224	258	281	304	315	328	359
Seneca	204	237	272	296	321	332	345	378
Steuben	159	184	212	231	250	259	269	295
Suffolk	309	358	412	449	486	503	523	573
Sullivan	211	244	281	306	332	343	357	391
Tioga	201	233	268	292	316	327	340	373
Tompkins	217	251	289	315	341	353	367	402
Ulster	263	305	350	382	413	427	445	486
Warren	215	250	287	313	339	350	364	399
Washington	199	231	265	289	313	323	337	368
Wayne	207	240	276	301	326	337	351	384
Westchester	271	314	361	393	426	440	474	536
Wyoming	199	231	265	289	313	323	337	368
Yates	181	210	241	263	284	294	306	335

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(b) When the recipient is obligated to pay for water as a separate charge to a vendor, an allowance must be made for the additional amount required to be paid. When the recipient is obligated to pay for sewer, water (except when paid as a separate charge) and/or garbage disposal, an allowance must be made therefor to the extent that the total of the rent allowances plus such charge or charges does not exceed the appropriate maximum amount in the schedule in subdivision (a) of this section. For the purpose of this subdivision, the term "separate charge" refers to a billing made directly to a recipient in his or her name, which is limited to charges for his or her utility service.

(c) An allowance for household expenses must be made for a period not in excess of 180 days, when essential to retain a housing accommodation and to maintain the home to which a recipient temporarily receiving care in a medical facility is reasonably expected to return upon discharge from such facility. Payments under this subdivision must not continue for more than 45 days unless, within 45 days following placement in the medical facility, the social services official has reviewed the recipient's status and determined that the recipient is expected to remain in the facility for not more than 180 days and is likely to return to the home following discharge. The basis for these conclusions must be documented in the case record.

(d) (1) Public housing. An allowance for rent must be made for recipients who are tenants of city, State or federally aided public housing up to the amount actually paid or the following schedule, whichever is less, except when a modified schedule of allowances is approved by this department for a specific housing authority or when the housing authority calculates the rent based on a percentage of household income:

Apartment size	Monthly rent
"0" Bedrooms	\$ 65
1 Bedroom	77
2 Bedrooms	90
3 Bedrooms	101
4 Bedrooms	107
5 Bedrooms	110

(i) Modified scheduled approved. When a modified schedule is approved by this department for a specific housing authority, the allowance for rent must be the amount actually paid up to the approved schedule amount.

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- (ii) Rent calculated based on a percentage of income. For any household for which the amount of rent is determined by a public housing authority as a percentage of either gross or adjusted gross income, the applicable shelter allowance is the amount so calculated up to the maximum allowance for the given household size found in subdivision (a) of this section.
- (2) (i) Section 236 Rental Assistance Program, Section 8 Housing Vouchers, Section 8 Housing Program (non-certificate). The rent allowance for tenants of housing subsidized under the Section 236 Rental Assistance Program or the Section 8 Housing Assistance Payments Program, except as provided in clause (ii) of this paragraph, is the amount of rent actually paid (exclusive of the subsidy) but not more than the amount in the applicable schedule in subdivisions (a) and (b) of this section.
- (ii) Section 8 Existing Housing Program (certificate). The rent and fuel for heating allowance for recipients whose housing payments of rent are subsidized under the Section 8 Existing Housing Program who hold a certificate of family participation (not including a recipient participating in the program of special allowances for owners of manufactured homes) is the amount in the applicable schedule in clause (iii) or clause (iv) of this paragraph. Such amount will not be adjusted in accordance with the actual cost of shelter and utilities. Subdivisions (a) and (b) of this section and subdivision (a) of section 352.5 do not apply; provided, however, that allowances hereunder may not exceed the applicable amount under subdivision (a) of this section. Shelter and fuel allowances pursuant to this subdivision are not subject to proration under section 352.32(e)(2)(ii) of this Part unless the members of each assistance unit in the household reside together as a single economic unit subject to proration of the basic monthly allowance, the home energy allowance and the supplemental home energy allowance under section 352(e)(2)(i) of this Part. Any amounts by which the rental obligation of the tenant is reduced below the amounts in the applicable schedule in clause (iii) or clause (iv) of this paragraph as an allowance for payment of utilities and any amounts remitted to the tenant or to a vendor for payment of utilities as a result of participation in the section 8 program are deemed to be an actual payment for housing by the tenant for the purposes of this clause. No such utility allowance or reimbursement constitutes income for purposes of determining eligibility for or the amount of public assistance.

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(iii) Local agency maximum monthly section 8 rent allowances

By Family Size (No recipient having earned income which is or may be exempt under Section 352.19 of this Part)

Number of Persons Receiving Assistance in Household

Number of children under 18	1	2	3	4	5	6	7	8	Each additional person
0	\$59	\$94	\$125	\$161	\$198	\$229	\$260	\$291	\$31
1	\$42	\$77	\$108	\$144	\$181	\$212	\$243	\$274	
2		\$60	\$91	\$127	\$164	\$195	\$226	\$257	
3			\$74	\$110	\$147	\$178	\$209	\$240	
4				\$93	\$130	\$161	\$192	\$223	
5					\$113	\$144	\$175	\$206	
6						\$127	\$158	\$189	
7							\$141	\$172	
								\$155	

For each additional dependent child in the household under the age of 18 years, subtract \$17.

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(iv) Local agency maximum monthly section 8 rent allowances

**By Family Size**  
(At least one recipient having earned income  
subject to disregard as a work expense)

**Number of Persons Receiving Assistance in Household**

Number of children under 18	1	2	3	4	5	6	7	8	Each additional person
0	\$98	\$133	\$164	\$200	\$237	\$268	\$299	\$330	\$31
1	\$81	\$116	\$147	\$183	\$220	\$251	\$282	\$313	
2		\$99	\$130	\$166	\$203	\$234	\$265	\$296	
3			\$113	\$149	\$186	\$217	\$248	\$279	
4				\$132	\$169	\$200	\$231	\$262	
5					\$152	\$183	\$214	\$245	
6						\$166	\$197	\$228	
7							\$180	\$211	
									\$194

For each additional dependent child in the household under the age of 18 years, subtract \$17.

(e) Rent allowances for hotel/motel facilities. An allowance for shelter must be made for recipients temporarily housed in hotel/motel facilities under the following circumstances:

- (1) No other suitable housing either public or private is available to house the recipient.
- (2) Hotel/motel accommodations without cooking facilities must be utilized only when accommodations with such facilities are not available. An allowance for the actual cost of the rental of a refrigerator, not to exceed \$10 per week per room, must be made when a homeless family is temporarily placed in a hotel/motel which does not have cooking facilities and which provides a refrigerator on a rental basis.
- (3) The continued need for hotel/motel accommodations must be reviewed, evaluated and authorized monthly by the social services district.

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- (4) A detailed report of that review, evaluation and authorization must be submitted to the department's division of income maintenance on the form prescribed by the department, on or before the 10th working day of the fourth month of temporary residence, and at monthly intervals thereafter.
- (f) Reimbursement for shelter costs and restaurant allowances and rental fees for refrigerators as provided for in paragraph (e)(2) of this section is available to social services districts for expenditures made by such districts on behalf of recipients temporarily living in hotels or motels for so long as the recipients are actively seeking permanent housing, but in no event for a period in excess of six months unless the local commissioner of social services determines on an annual basis that housing other than hotels or motels or facilities regulated under Part 900 of this Title is not readily available in the social services district and the commissioner submits such determination to the department on an annual basis. Upon such a determination and submission, the social services district will continue to be reimbursed for shelter costs, restaurant allowances as appropriate and rental fees for refrigerators provided to public assistance recipients beyond such six month period. A recipient's continued need for hotel/motel accommodations must be reviewed and evaluated monthly. The maximum reimbursable amount for shelter costs after August 1, 1984 is \$16 per day for the first person in each hotel room, and \$11 per day for the remaining occupants in each room. Restaurant allowances, if necessary, must be provided in accordance with department regulations.
- (g) Standards. No family must be referred to a hotel/motel, nor must any reimbursement be made for costs incurred from such referral unless all of the requirements set forth below are met:
- (1) Primary consideration must be given to the needs of children. Specific factors considered must include but must not be limited to educational needs, security, the nature of the facility in which the children would be placed, and factors which will insure the minimum disruption of community ties.
- (2) The hotel/motel must have appropriate contractual or other arrangements for maintenance, repair and sanitation in the hotel/motel. The hotel/motel must have available for review by the local social services district information verifying the above-mentioned arrangements or record of such. Such information would include, for example, contracts with private carters, bills, receipts, or other evidence of performance. Such arrangements must include but not be limited to agreements for provision of the following services:
- (i) removal of garbage;

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- (ii) maintenance of floor coverings, draperies and furniture;
  - (iii) repainting of the facility at least once every five years;
  - (iv) maintenance and inspection of the electrical system;
  - (v) maintenance of plumbing and plumbing fixtures;
  - (vi) maintenance and inspection of heating, ventilation and air conditioning systems;
  - (vii) a regular vermin control program; and
  - (viii) provision to insure that entrances, exits, steps and walkways are kept clear of garbage, ice, snow and other hazards.
- (3) Rooms must be cleaned at least every other day by hotel/motel staff.
- (4) Furniture necessary for daily living, including but not limited to tables, bureaus, chairs, beds and cribs must be in each room.
- (5) No more than two adults must be placed in the same room.
- (6) When children are placed in the same room as adults, there must be sufficient beds so children must not have to share single beds.
- (7) All mattresses and bedding material must be clean. Each bed must have at least two clean sheets, adequate clean blankets, clean pillows and pillowcases. A complete change of linens must be made by hotel/motel staff at least once a week and more often where individual circumstances warrant or when a new family occupies the unit. Each unit must be supplied with towels, soap and toilet tissues. A clean towel must be provided daily to each resident.
- (8) Each unit must have operational door and window locks. All windows at and above the second floor must have window guards in place unless windows are sealed and the air conditioning works.
- (9) A heating system must be permanently installed and operated in accordance with applicable local law. Where local law or code does not govern the provision of heat, the system will provide heat to maintain a temperature of 69°F (20°C) in all occupied parts of the building, including corridors. Where windows do not open, proper ventilation, including but not limited to air conditioning, must be operational.

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(10) Each family must have a private bathroom. At a minimum, this must include a toilet, a sink and a shower or bathtub, all of which must be properly maintained with hot and cold running water. Couples without children may be placed in rooms with common bathroom facilities.

(h) Inspection. Local social services districts which make hotel/motel referral must inspect at least once every six months the hotels/motels in which families are placed. In addition to verifying that the hotel/motel meets the requirements set forth in subdivision (g) of this section, the local district must make appropriate inquiries to determine whether the hotel/motel is in compliance with all applicable state and local laws, regulations, codes and ordinances. Any violation found during the on-site inspection must be reported to appropriate authorities. Further, each inspection must at least review arrangements for hygiene, vermin control, security, furnishings, cleanliness and maintenance and must include a review of any applicable documents pertaining to compliance with any local laws or codes. A written report must be made of each such inspection and must be maintained at the office of the local district together with such other information as the district may maintain concerning the families placed in the hotel/motel.

(i) (1) To the extent that units of housing are available and subject to department approval based upon the housing conditions in the region, social services districts may provide an allowance to secure housing to any homeless family:

(i) residing in a municipality having a rental vacancy rate for low-income housing less than three percent;

(ii) for whom no housing can be located at a rent within the shelter maximum under this section; and

(iii) in which at least one member of the family has resided in a hotel or motel and/or a shelter (including, but not limited to, facilities operated under Part 900 of this Title) at public expense for a period exceeding 12 weeks. Social services districts may consider decreasing this length of stay requirement if a long term temporary placement in a hotel or motel or shelter would be detrimental to the health and welfare of families, including families with immediate medical needs.

(2) In determining priority for placement in housing units for which an allowance is paid under this subdivision, the district must consider factors affecting need such as:

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- (i) the length of stay in a hotel or motel and/or a shelter (including, but not limited to, facilities operated under Part 900 of this Title) at public expense;
  - (ii) the size of the family; and
  - (iii) the location of schools in relation to the temporary housing where the family is residing.
- (3) Social services districts must submit to the department for approval annual plans for the operation of programs to make allowances available under this subdivision. Plans must be submitted within 45 days after funds have been authorized in the State budget for allowances for this program.
- (i) indicate the number of units of housing for which the allowance will be made available pursuant to this subdivision, identifying the number that would be privately owned units and the number that would be publicly owned units, and the amount of funds being requested,
  - (ii) describe the housing to be utilized,
  - (iii) indicate the number of months that the allowance will be available (not to exceed eight months in the case of privately owned units or four months in the case of publicly owned units),
  - (iv) set forth the procedures for assuring local housing code compliance,
  - (v) set forth the procedures to identify those families likely to be long-term residents of hotels and motels and/or shelters (including, but not limited to, facilities operated under Part 900 of this Title)
  - (vi) indicate the criteria to be used in determining priorities for placement,
  - (vii) indicate the services available in the social services district to assist persons to remain in housing after placement under this program;
  - (viii) indicate the number of homeless facilities in the social services district that requested emergency housing each month during the most recent twelve month period and the number of families that resided in hotels and motels and/or shelters during the most recent twelve month period; and

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(ix) indicate the number of months that the social services district will require participating landlords to make specified apartments available to selected families.

(4) The allowance consists of a rent supplement in an amount to be determined by the social services district, with the prior approval of the department, but cannot exceed the difference between the maximum shelter allowance and the hotel/motel rate for the family. Social services districts must submit claims for State reimbursement for such allowances on forms and in the manner prescribed by the department.

(5) No allowance will be paid under this subdivision for housing developed for the homeless financed partially or wholly with public funds.

(6) No allowance under this subdivision will be paid unless the social services district documents that such allowance will not be used to replace funds previously used, or designated for use, to secure housing for homeless families.

(7) No allowance provided under this subdivision will be paid for housing which does not comply with or which is not brought into substantial compliance with the local housing code or which has been occupied by a family receiving Family Assistance (FA) or Safety Net Assistance (SNA) within one year prior to the payment of an allowance hereunder; provided, however, that such allowance may be held in escrow by the district pending correction of existing code violations. Moreover, no allowance will be paid unless the participating landlord agrees to make a specified apartment available to the selected family for a period of up to 32 months as approved by the department, except as provided herein. The landlord must agree that, in the event that a selected family does not remain for any reason in the specified apartment for the period for which it is to be available, the landlord will return a pro rata portion of the allowance reflecting the balance of the period. In such event, the district may provide an allowance with respect to a subsequently selected family for the balance of the period, provided further that such family meets the eligibility criteria set forth in this subdivision.

(8) Allowances provided under this subdivision must be paid for a maximum period specified by the district and approved by the department.

(9) Social services districts providing allowances under this subdivision must submit information on a monthly basis in a manner prescribed by the department, including but not limited to:

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- (i) the number of units rented that were privately owned and the number of units rented that were publicly owned and the addresses of such units;
  - (ii) the individual allowances issued; and
  - (iii) the number of families leaving apartments funded with allowances under this subdivision.
- (j) If rent has not been paid for the month in which the case is accepted, a non-prorated shelter allowance, not to exceed the appropriate local agency maximum monthly shelter allowance, must be provided to retain the living accommodation.
- (k) Emergency shelter allowances:
- (1) An emergency shelter allowance must be provided, upon request, to a household composed of an applicant for or recipient of public assistance, who has been medically diagnosed as having AIDS or HIV-related illness as defined from time-to-time by the AIDS Institute of the State Department of Health, and any family members residing with such person. Such household must be homeless or faced with homelessness and have no viable and less costly alternative housing available. The social and medical needs of the household members must be considered in making a determination concerning the availability of alternative housing.
  - (2) An emergency shelter allowance must not exceed \$480 for the first person in the household and \$330 for each additional person in the household, and in no event be greater than the actual monthly rent due. A person with AIDS or HIV-related illness is considered to be the first person in the household. Except for cases specified in paragraph (3) of this subdivision, the emergency shelter allowance is considered to be the household's public assistance shelter allowance for public assistance budgeting purposes.
  - (3) When a household comprising both FA and SSI eligible persons requests an emergency shelter allowance, the social services district must compute the amount of the allowance as follows:
    - (i) determine the public assistance grant of the FA eligible persons using the appropriate rent schedule amount in section 352.3(a) of this Part;

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- (ii) calculate the net amount of actual household shelter costs by subtracting the appropriate rent schedule amount, as determined by referring to section 352.3(a) of this Part, from the total actual household shelter costs;
- (iii) calculate the maximum amount of emergency shelter allowance available to the household by subtracting the appropriate rent schedule amount, as determined by referring to section 352.3(a) of this Part, from the maximum allowance authorized by paragraph (2) of this subdivision for the total number of persons in the household; and
- (iv) subtract the SSI benefits and other income of the SSI eligible persons from the sum of the amount calculated in accordance with the provisions of subparagraph (ii) or subparagraph (iii) of this paragraph, whichever is less, and the incremental non-shelter public assistance standard of need of the SSI eligible persons. The resulting amount, if greater than zero, is the household's emergency shelter allowance. This allowance is added to the public assistance grant determined in accordance with subparagraph (i) of this paragraph.
- (4) When necessary, social services districts must:
- (i) address the social services needs of a person in receipt of an emergency shelter allowance through the direct provision of services or through the provision of appropriate information and referral services; efforts should be made to ensure that an applicant for or a recipient of such an allowance has established appropriate social and medical support networks;
- (ii) assist an applicant for or a recipient of an emergency shelter allowance to secure the required documentation so that eligibility for such allowance can be determined; and
- (iii) arrange for required face-to-face interviews to be conducted during home visits or at other appropriate sites. In accordance with department regulations, designated representatives may file and sign application and recertification documents on behalf of an applicant for or a recipient of an emergency shelter allowance.

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**352.4 Shelter costs for applicant/recipient-owned property.**

(a) Purchase of interest in low cost housing development.

(1) A social services official may approve a grant, not to exceed \$2,500 toward the purchase of an interest in a cooperative unit in a low cost housing development.

(2) The social services official must require assignment of applicant's/recipient's equity in such cooperative housing.

(b) Carrying charges. On applicant/recipient-owned property used as a home, carrying charges must be met in the amount actually paid by the applicant/recipient, but not in excess of the appropriate maximum of the rent schedule, for the items of taxes; interest on mortgage; fire insurance; and garbage disposal, sewer and water assessments.

(c) Amortization. The amounts required to amortize a mortgage on the applicant's/recipient's property must be included in the carrying charges when property is income-producing and the resulting carrying charges do not exceed the property income by an amount in excess of the maximum of the established rent schedule or when property is not income-producing but it is essential to retain the home of the applicant/recipient and the resulting carrying charges do not exceed the appropriate maximum of the established rent schedule.

(d) Property repairs. The cost of property repairs must be met when:

(1) the property is income-producing and the repairs are essential to retain that status; or

(2) the repairs are essential to the health or safety of the applicant/recipient.

(e) Shelter costs of property deeded to social services official.

(1) Property on which a social services official has taken a deed under the provisions of section 106 of the Social Services Law may be used to shelter a public assistance recipient whether it be the recipient who conveyed such property or other recipient.

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(2) Except in cases when property is used to shelter a surviving spouse of a former recipient who conveyed such property, it must be used to shelter other recipients only for a period of one year subsequent to the date of the death of the recipient who conveyed such property. After the expiration of a six-month period from such date of death but on or before the expiration of such one year, appropriate action must be taken to initiate a sale of such property in accordance with the provisions of section 106 of the Social Services Law.

(3) In cases in which property conveyed to a social services official is used to shelter a recipient other than the recipient who conveyed such property or his surviving spouse, a reasonable rental for such shelter must be determined. Such reasonable rental must be included in the grant of assistance of the recipient sheltered in such property and the net amount of such rent, in excess of all carrying charges paid for by the social services district, must be credited to the amount required to redeem the property as provided in section 106 of the Social Services Law.

**352.5 Energy assistance.**

(a) Tenant and customer of record requirements.

Prior to granting energy assistance under subdivisions (b) through (g) of this section, it must be documented that the applicant/recipient/grantee is the tenant and customer of record. A tenant of record is a person who has primary responsibility for payment of the monthly rent or mortgage for the dwelling unit. Individuals who contribute a portion of the monthly rent/mortgage to a person responsible for payment of the monthly rent/mortgage for the dwelling unit will not be considered a tenant of record. A customer of record is a person who has an account in his or her name with a home energy vendor. An individual who is not the tenant and customer of record considered to meet the tenant and customer of record requirement(s) when such individual is the spouse of the tenant and customer of record who is living in the same household or who is the surviving spouse of a deceased spouse who was the tenant and customer of record. The term home energy vendor means an individual or entity engaged in the business of selling electricity, natural gas, oil, propane, kerosene, coal, wood, or any other fuel used for residential heating and/or domestic (lights, cooking, hot water) energy.

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(b) Fuel for heating allowances.

Each social services district must grant an allowance for fuel for heating to a public assistance applicant/recipient or self-maintaining grantee in receipt of public assistance for a dependent child or children when it is documented that the applicant/recipient/ grantee is the tenant of record, as defined in subdivision (a) of this section, with primary responsibility for payment of the residential heating costs. A fuel for heating allowance must also be granted to a public assistance applicant/recipient/grantee whose utility heating bill may include costs for service for the applicant/recipient/grantee's own residential unit and for space outside that unit or whose non-utility heating bill includes costs for the applicant/recipient/grantee's own residential unit and for other residential units when it is documented that the applicant/recipient/grantee is the tenant and customer of record as defined in subdivision (a) of this section. When a fuel for heating allowance is granted to an applicant/recipient/grantee who is the customer of record for a utility bill which may include costs for service for the applicant/recipient/grantee's own residential unit and for space outside that unit, the social services district must determine whether a referral for a shared meter investigation, in accordance with the provisions of section 52 of the Public Service Law, is appropriate. A fuel for heating allowance is not granted to an applicant/recipient/grantee budgeted in accordance with the Section 8 certificate housing provisions outlined in section 352.3(d)(2)(ii) of this Part. To have primary responsibility for the payment of residential heating costs, the applicant/recipient/grantee must be the customer of record, as defined in subdivision (a) of this section, for the residential heating bill with a home energy vendor. Fuel for heating allowances must be provided on a 12-month heating season (October 1st September 30th) in accordance with the following schedules and must be based upon the applicant/recipient/grantee's primary residential heating source:

SCHEDULE SA-6a  
MONTHLY ALLOWANCES FOR FUEL FOR HEATING  
BEGINNING OCTOBER 1, 1987:  
Oil, Kerosene, Propane

Counties of: Nassau, New York City, Suffolk, Westchester

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$70	70	70	73	77	82	88	93

Counties of: Chautauqua, Dutchess, Orange, Putnam, Rockland, Ulster

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$68	68	68	71	74	80	85	91

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Counties of: Columbia, Erie, Genesee, Livingston, Monroe, Niagara, Onondaga,  
Ontario, Orleans, Oswego, Wayne

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$69	69	69	72	75	81	87	92

Counties of: Albany, Cayuga, Chemung, Greene, Schenectady, Schuyler, Seneca,  
Tompkins, Yates

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$69	69	69	72	75	81	87	92

Counties of: Allegany, Broome, Cattaraugus, Chenango, Cortland, Delaware, Fulton,  
Jefferson, Madison, Montgomery, Otsego, Rensselaer, Saratoga, Schoharie,  
Steuben, Sullivan, Tioga, Warren, Washington, Wyoming

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$72	72	72	75	78	84	90	96

Counties of: Clinton, Lewis, Oneida, St. Lawrence

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$71	71	71	74	78	83	89	95

Counties of: Essex, Franklin, Hamilton, Herkimer

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$77	77	77	80	84	90	96	102

**SCHEDULE SA-6b  
MONTHLY ALLOWANCES FOR FUEL FOR HEATING  
BEGINNING OCTOBER 1, 1987:  
Natural Gas, Coal, Wood, Municipal Electric Utilities  
not Regulated by the Public Service Commission,  
Any Other Fuel not Covered by SA-6a and SA-6c**

Counties of: Nassau, New York City, Suffolk, Westchester

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$56	56	56	58	61	65	69	74

Counties of: Chautauqua, Dutchess, Orange, Putnam, Rockland, Ulster

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$55	55	55	57	60	64	68	73

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Counties of: Columbia, Erie, Genesee, Livingston, Monroe, Niagara, Onondaga, Ontario,  
Orleans, Oswego, Wayne

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$54	54	54	56	58	63	67	71

Counties of: Albany, Cayuga, Chemung, Greene, Schenectady, Schuyler, Seneca,  
Tompkins, Yates

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$58	58	58	60	63	68	72	77

Counties of: Allegany, Broome, Cattaraugus, Chenango, Cortland, Delaware, Fulton,  
Jefferson, Madison, Montgomery, Otsego, Rensselaer, Saratoga, Schoharie,  
Steuben, Sullivan, Tioga, Warren, Washington, Wyoming

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$58	58	58	60	63	67	72	77

Counties of: Clinton, Lewis, Oneida, St. Lawrence

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$55	55	55	57	60	64	69	73

Counties of: Essex, Franklin, Hamilton, Herkimer

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$66	66	66	68	71	77	82	87

SCHEDULE SA-6c  
MONTHLY ALLOWANCES FOR FUEL FOR HEATING  
BEGINNING OCTOBER 1, 1987:

Public Service Commission-Regulated Electric Utilities, Village of Greenport Electric

Counties of: Nassau, New York City, Suffolk, Westchester

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$90	90	90	94	99	106	113	120

Counties of: Chautauqua, Dutchess, Orange, Putnam, Rockland, Ulster

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$105	105	105	109	114	123	131	139

Counties of: Columbia, Erie, Genesee, Livingston, Monroe, Niagara, Onondaga, Ontario,  
Orleans, Oswego, Wayne

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$107	107	107	111	117	125	134	142

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Counties of: Albany, Cayuga, Chemung, Greene, Schenectady, Schuyler, Seneca,  
Tompkins, Yates

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$120	120	120	125	131	140	150	160

Counties of: Allegany, Broome, Cattaraugus, Chenango, Cortland, Delaware, Fulton,  
Jefferson, Madison, Montgomery, Otsego, Rensselaer, Saratoga, Schoharie,  
Steuben, Sullivan, Tioga, Warren, Washington, Wyoming

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$122	122	122	127	133	142	152	162

Counties of: Clinton, Lewis, Oneida, St. Lawrence

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$122	122	122	127	133	143	153	163

Counties of: Essex, Franklin, Hamilton, Herkimer

Number of persons	1	2	3	4	5	6	7	8+
12 month	\$140	140	140	146	153	164	175	186

(c) Payment essential to obtain non-utility heating fuel for an applicant for family assistance (FA), safety net assistance (SNA), veteran assistance or emergency public assistance. The district must authorize a nonrecoupable payment to an applicant for family assistance, safety net assistance, veteran assistance or emergency public assistance for non-utility (other than natural gas or electricity) heating fuel, including an applicant whose non-utility heating bill includes costs for the applicant's own residential unit and for other residential units, provided such payment is necessary to obtain non-utility heating fuel essential for the applicant's residential heating purposes. Such payment may only be made when it is documented that the applicant is the tenant of record and the customer of record, as defined in subdivision (a) of this section, and alternative payment or housing accommodations cannot be arranged and the applicant is without liquid resources to pay for such non-utility heating fuel. Such payment must not exceed the cost of non-utility heating fuel required to meet the applicant's immediate need. However, once an initial payment has been authorized for an applicant whose non-utility heating bill includes costs for the applicant's own residential unit and for other residential units, subsequent emergency payments to obtain non-utility heating fuel for that applicant may only be authorized for deliveries made on an alternate basis with the other unit(s) sharing the fuel source. Prior to issuing payment for each subsequent delivery, it must be documented that heating fuel in amounts reasonably comparable to the most recent delivery paid for by the social services district has been provided by or on behalf of the other unit(s) sharing the fuel source. When the alternate delivery requirement has not been met or cannot be

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documented, the social services district must address the applicant's hearing emergency with alternative methods. These methods include, but are not limited to, the following: referrals to services and/or other agencies; exploration of alternative housing; exploration of other funding sources (including HEAP); or the lending of safe supplemental heating devices. Documentation of need for the social services district payment must be fully recorded in the applicant's case file.

(d) Payment essential to obtain non-utility heating fuel. This subdivision applies to recipients of family assistance, safety net assistance, veteran assistance, or self-maintaining grantees in receipt of family assistance or safety net assistance on behalf of dependent children and in receipt of fuel for heating allowances as outlined in subdivision (b) of this section. An advance allowance subject to recoupment, in accordance with section 352.11 of this Part, must be authorized for such recipient or grantee when it is documented that the recipient/grantee is the tenant and customer of record for the residential heating bill, as defined in subdivision (a) of this section, and when the recipient/grantee has made a request in writing for such an allowance and also has requested in writing that the monthly grant be reduced to recover the advance allowance. This provision is applicable in those cases where the recipient/grantee's non-utility heating bill includes costs for the recipient/grantee's own residential unit and for other residential units. Once an initial payment has been authorized for a recipient/grantee whose non-utility heating bill includes costs for the recipient/grantee's own residential unit and for other residential units, subsequent payments to obtain non-utility heating fuel for that recipient/grantee may only be authorized for deliveries made on an alternate basis with the other unit(s) sharing the fuel source. Prior to issuing payment for each subsequent delivery, it must be documented that heating fuel in amounts reasonably comparable to the most recent delivery paid for by the social services district has been provided by or on behalf of the other unit(s) sharing the fuel source. When the alternate delivery requirement has not been met or cannot be documented, the social services district must address the recipient/grantee's heating emergency with alternative methods. These methods include, but are not limited to, the following: referrals to services and/or other agencies; exploration of alternative housing; exploration of other funding sources (including HEAP); or lending of safe supplemental heating devices.

(e) Payment essential to continue or restore utility service for an applicant for family assistance, safety net assistance, veteran assistance or emergency public assistance. A payment must be made for utilities previously provided to an applicant for family assistance, safety net assistance, veteran assistance or emergency public assistance if such payment is essential to continue or restore utility service. Payment essential to continue or restore utility service may be provided to an applicant whose utility bill includes costs for service for the applicant's own residential unit and for space outside that unit. Payment may only be made when it is documented that the applicant is the tenant of record and the customer of record, as defined in subdivision (a) of this section, and

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alternative payment or housing accommodations cannot be made and the applicant is without liquid resources to continue or restore utility service. Payment must not exceed the cost of utilities provided to the applicant during the four most recently completed monthly billing periods or two most recently completed bi-monthly billing periods for which a bill has been issued immediately preceding the date of application for such assistance. Payment is limited to the applicant's proportionate share of the cost of service for the most recently completed four monthly or two most recently completed bi-monthly billing periods for which a bill has been issued immediately preceding the date of application for such assistance when the applicant's utility bill includes costs for service for the applicant's own residential unit and for space outside that unit. Payment must not exceed the balance due on the account. In a shared meter situation subject to the provisions of section 52 of the Public Service Law, the proportionate share is to be determined by the utility company's apportionment of retroactive charges upon completion of a shared meter investigation and determination. As a condition of receiving such assistance, an applicant not in receipt of recurring public assistance or supplemental security income whose gross monthly household income on the date of application exceeds the public assistance standard of need for the same size household must sign an agreement to repay the assistance within one year of the date of the payment. A household consists of all persons who occupy a housing unit. A house, an apartment or other group of rooms, or a single room is regarded as a housing unit when it is occupied or intended for occupancy as separate living quarters. A household includes related family members and all unrelated persons, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone, or a group of unrelated persons sharing a housing unit as partners, also constitutes a household. The public assistance standard of need is determined by applying the following statewide standards of need in accordance with office regulations: the pre-add allowance as set forth in Schedule SA-2a of section 352.3 of this Part; the shelter allowance as paid, but not to exceed the maximum allowance set forth in section 352.3 of this Part; the fuel allowance set forth in Schedule SA-6a, SA-6b or SA-6c of section 352.5 of this Part, if the applicant is the tenant of record and customer of the record for the residential heating bill; the home energy and supplemental home energy payments (HEA and SHEA) as set forth in schedule SA-2b or SA-2c of section 352.1 of this Part; and, if applicable, the additional cost of meals for persons unable to prepare meals at home as set forth in schedule SA-5 of section 352.7 of this Part. The repayment agreement must set forth a schedule of payments that will assure repayment within one year of the date of payment. Subsequent assistance to continue or restore utility service must not be provided unless any prior utility arrearage payments have been repaid or are being repaid in accordance with the schedule of payments contained in each prior repayment agreement as of the date of application for such subsequent assistance. Repayment agreements under this subdivision may be enforced in any manner available to a creditor, in addition to any other remedy the district may have pursuant to the Social Services Law.

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(f) Payment essential to continue or restore utility service for a recipient of family assistance, safety net assistance, veteran assistance, or self-maintaining grantee in receipt of public assistance for dependent children and in receipt of a home energy allowance and supplemental home energy allowance (HEA and SHEA) and/or a fuel for heating allowance, as defined in subdivision (b) of this section. For purposes of this subdivision, the term recipient is defined as: a recipient of family assistance, safety net assistance, veteran assistance, or a self-maintaining grantee in receipt of public assistance on behalf of dependent children and in receipt of a HEA and SHEA and/or a fuel for heating allowance, as defined in subdivision (b) of this section.

(1) A payment must be made for utilities previously provided to a recipient of family assistance, safety net assistance, veteran assistance or grantee in receipt of public assistance for dependent children and in receipt of an HEA and SHEA and/or a fuel for heating allowance, as defined in subdivision (b) of this section if such payment is essential to continue or restore utility service. Payment essential to continue or restore utility service may be provided to a recipient whose utility bill includes costs for service for the recipient's own residential unit and for space outside that unit. Payment may only be granted when it is documented that the recipient/grantee is the tenant and customer of record, as defined in subdivision (a) of this section and when alternative payment or housing accommodations cannot be made and the recipient is without liquid resources to continue or restore utility service. Payment must not exceed the cost of utilities provided to the recipient for the four most recently completed monthly billing periods or two most recently completed bi-monthly billing periods in which service was rendered within the 10 monthly or five bi-monthly most recently completed billing periods immediately preceding the date of request for such assistance. When the recipient's utility bill includes costs for service for the recipient's own residential unit and for space outside that unit, payment is limited to the recipient's proportionate share of the cost of service for the time frames outlined above. In a shared meter situation subject to the provisions of section 52 of the Public Service Law, the proportionate share is to be determined by the utility company's apportionment of retroactive charges upon completion of a shared meter investigation and determination. Payment must not exceed the balance due on the account and must be provided in accordance with the provisions of paragraphs (2), (3) and (4), (5), (6), and (7) of this subdivision.

(2) Payment must be provided as a nonrecoupable grant when it is documented that during the period specified in paragraph (1) of this subdivision the recipient has fully applied the public assistance grant to purposes intended to be included in such grant. Such documentation for recipients not budgeted in accordance with the Section 8 certificate housing provisions outlined in section 352.3(d)(2)(ii) of this Part must include proof of payment of: an amount at least equal to the combined

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Home Energy Allowance and supplemental Home Energy Assistance (HEA and SHEA) budgeted in the public assistance grant to domestic (lights, cooking, hot water) energy costs; the monthly fuel for heating allowance budgeted in the public assistance grant to incurred heating costs; and the monthly shelter allowance budgeted in the public assistance grant to shelter costs. In addition, there must be no other evidence of mismanagement. Documentation for recipients budgeted in accordance with the provisions outlined in section 352.3(d)(2)(ii) of this Part must include proof of payment of: an amount at least equal to the combined Home Energy Allowance and Supplemental Home Energy Allowance (HEA and SHEA) budgeted in the public assistance grant to domestic energy costs (lights, cooking, hot water); an amount at least equal to the shelter allowance budgeted in the public assistance grant towards shelter, heating, water, and other shelter-related items covered by the federal Department of Housing and Urban Development utility allowance. In addition, there must be no other evidence of mismanagement.

(3) If such recipient is not eligible for a nonrecoupable grant pursuant to paragraph (2) of this subdivision, or for other available non-recoupable grants including Home Energy Assistance Program benefits, payment must be provided as an advance allowance subject to recoupment in accordance with section 352.11 of this Part.

(4) Whenever a social services district makes an arrearage payment to continue or restore the utility service of a public assistance recipient, the district must also, prospectively for a period of six months or until the case is closed, whichever occurs first, act as a guarantor of the recipient's future utility bills or place the recipient on voucher payment. When the recipient is the customer of record for a utility bill which includes costs for service for the recipient's own residential unit and for space outside that unit, only the recipient's proportionate share of the bill is the prospective responsibility of the social services district.

(5) If the agency uses a voucher payment to meet the prospective responsibility for an FA recipient the agency must be able to document recipient mismanagement. For the purposes of this subdivision, mismanagement is determined in accordance with the provisions outlined in paragraph (2) of this subdivision. In such cases, amounts not to exceed the following are restricted from the recipient's grant:

(i) if the recipient's utility bill represents "heat only," and the recipient does not reside in or is not budgeted in accordance with the Section 8 certificate housing provisions outlined in section 352.3(d)(2)(ii) for this Part, the recipient's monthly fuel for heating allowance is removed from the recipient's monthly grant. If the recipient's utility bill represents "heat only"

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and the recipient does reside in Section 8 certificate housing or is budgeted in accordance with section 352.3(d)(2)(ii) of this Part, the balance of the shelter allowance minus the actual rent obligation, up to an amount equal to the appropriate fuel allowance schedule set forth in subdivision (b) of this section for the appropriate heating type and public assistance household size, is removed from the grant. Heating costs paid by the district which exceed the amount removed from the recipient's grant are considered to be overpayments subject to recoupment in accordance with section 352.31(d) of this Part;

(ii) if the recipient's utility bill represents domestic costs only (lights, cooking, hot water), the recipient's Home Energy Allowance and Supplemental Home Energy Allowance (HEA and SHEA) or the average monthly cost of the recipient's domestic utility service, whichever is less, is removed from the recipient's grant. Domestic energy costs paid by the district which exceed the amount removed from the grant must be considered to be overpayments subject to recoupment in accordance with section 352.31(d) of this Part.

(iii) if the recipient's utility bill represents heat and domestic costs, a combination of the amounts outlined in subparagraphs (i) and (ii) of this paragraph is removed from the grant. If the recipient's combined heat and domestic costs exceed the amounts removed from the recipient's grant, the balance must be considered an overpayment subject to recoupment in accordance with section 352.31(d) of this Part.

(6) If the agency uses a vendor payment to meet the prospective responsibility for an SNA recipient, the agency may do so in accordance with section 381.3(c)(2) of this Title.

(7) When a recipient has been placed on vendor payment, whereby the social services district pays the energy vendor directly, as a result of mismanagement by the recipient or for administrative ease, the district must at least annually, at case closing, and upon termination of the vendor payment arrangement, determine if there has been an under/overpayment. Identified underpayments/overpayments are to be reconciled in accordance with section 352.31(d),(e), and/or (f) of this Part.

(g) (1) For recipients with heating costs in excess of their annual allowance provided pursuant to the schedules set forth in this section, the district should explore the possibility of alternative housing (renters only) and/or weatherization/conservation services.

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- (2) Recipients who retain responsibility for the payment of their own heating bills should be made aware of and encouraged to use budget billing programs offered by their heating vendors.
- (3) When the heating and/or domestic energy bill of a public assistance recipient/grantee has been placed on vendor payment as a result of a mismanagement determination, voluntary request, or administrative ease provision, the district must determine if there has been an under/overpayment. This reconciliation must be conducted at least annually, at case closing, and upon termination of the vendor payment arrangement. Identified under/overpayments are to be reconciled in accordance with section 352.31(d), (e), and/or (f) of this Part.
- (h) The social services official must designate a staff member to function as a liaison to energy vendors, other agencies, and to individuals seeking energy-related information and/or assistance.
- (i) The social services official must ensure that 24 hour/seven day a week referral capability exists for receipt of referrals from energy vendors, outside agencies, and individuals with energy related emergencies. The official may either designate social services district staff to be available on a 24 hour, seven days a week basis or may choose to designate an agency/organization in the community which agrees to accept calls after normal business hours and on weekends and to assist a referred household in the temporary alleviation of a life threatening energy emergency until the household can make application for financial assistance on the next normal business day.

**352.6 Miscellaneous shelter allowances and grants.**

- (a) (1) A social services official must provide funds for household moving expenses utilizing the least costly practical method of transportation, a rent security deposit, and/or a brokers' or finders' fee only when, in his judgment, one of the following conditions exists:
- (i) the move is to a less expensive rental property and the amount paid for a security deposit and moving expenses is less than the amount of a two-year difference in rentals; or
- (ii) the move is necessitated by one of the following criteria:
- (a) the need to move results from a disaster/catastrophe and/or a vacate order placed against the premises by a health agency or code enforcement agency;

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- (b) the move is necessitated by a serious medical or physical handicap condition. Such need must be verified by specific medical diagnosis;
  - (c) the individual or family is rendered homeless as a result of having been put out by another occupant with whom they were sharing accommodations;
  - (d) the move is from temporary to permanent housing;
  - (e) the move is from permanent housing to temporary housing whenever necessary due to the unavailability of permanent housing;
  - (f) the move is from one temporary accommodation to another temporary accommodation whenever necessary due to the unavailability of permanent housing;
  - (g) the move is from an approved relocation site or to an approved cooperative apartment; or
  - (h) there is a living situation which adversely affects the mental or physical health of the individual or family, and the need for alternate housing is urgent, and not issuing a security deposit, moving expenses and/or brokers' or finders' fees would prove detrimental to the health, safety and well-being of the individual or family.
- (2) A security deposit and/or brokers' or finders' fees must be provided only when an applicant or recipient is unable to obtain a suitable vacancy without payment of such allowances.
- (3) Documentation of the need for a security deposit, moving expenses and/or brokers' or finders' fees must be fully recorded in the case record.
- (b) Avoidance of abuses in connection with rent security deposits.
- (1) Whenever a landlord requires that he be secured against nonpayment of rent or for damages as a condition to renting a housing accommodation to a recipient of public assistance, a local social services official may secure the landlord by either of the following means:
    - (i) by means of an appropriate agreement between the landlord and the social services official; or

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- (ii) by depositing money in an escrow account, not under the control of the landlord or landlord's agent, subject to the terms and conditions of an agreement between the landlord and the social services official in such form as the department may require or approve; provided, however, that the provisions of this subparagraph do not apply where a public assistance recipient resides in public housing.
- (2) A social services official may not pay money to a landlord to be held as a security deposit against the payment of rent or for damages by a public assistance recipient, or issue a grant to a recipient of public assistance therefor, except as provided in paragraph (3) of this subdivision.
- (3) When, in the judgment of a social services official, housing accommodations available in a particular area are insufficient to accommodate properly recipients of public assistance in need of housing, and in order to secure such housing, it is essential that the official pay money to landlords to be held as security deposits against the non-payment of rent or for damages by public assistance recipients or to issue grants to recipients of public assistance therefor, such social services official may pay or furnish funds for such security deposits until sufficient housing accommodations are available in the particular area to accommodate properly recipients of public assistance in need of housing. Social services officials must not pay or furnish such funds where recipients of public assistance reside in public housing. In no case will temporary residence in a shelter, including those defined in Parts 900 or 1000 of this Title, a hotel/motel or any other such emergency or transitional residential facility be considered sufficient housing accommodations for purposes of this paragraph. Landlords receiving such security deposits must comply with the provisions of article seven of the General Obligations Law. The recipient is required to assign to the social services official any right the recipient may have to the return of the security deposit and interest accrued thereon. Any social services official paying or furnishing funds for a security deposit in accordance with this paragraph must make diligent efforts to recover such payments or funds from the landlord as allowed by law. Such efforts must not delay recoupment or recovery from a recipient if recoupment or recovery from the recipient is required by this section.

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(c) Recovery of rent security payments.

(1) If as a result of non-payment of the shelter allowance, the security deposit or security agreement for non-payment of rent is required to be paid to the landlord, such payment must be considered to be an overpayment made to the recipient and as such, must be recovered according to the provisions of section 352.31(d) of this Part. If rent has not been paid due to a legitimate landlord/tenant dispute, a rent strike or as a result of the application of Section 143-b of the Social Services Law, such payment is not an overpayment and cannot be recouped or recovered.

(2) When a security deposit or monies under a security agreement are paid to a landlord for damages caused by a recipient, such payment must be considered an overpayment and must be recovered from a recipient pursuant to the provisions of section 352.31(d) of this Part provided that a social services official has conducted (or arranged for) a pre-tenancy and post-tenancy inspection or survey of the premises, or verified by some other means that the damages were caused by the recipient. The condition of the premises when the recipient moves and when the recipient moves out must be documented and agreed to by signature of the landlord and the recipient. If the verification does not confirm that there are damages caused by the recipient, then cash must not be issued under a security agreement or, if a cash security deposit had been issued and the landlord retains it for alleged damages, the social services official must attempt to recover the deposit from the landlord. When the verification confirms that the recipient caused the damages, the district must recover the deposit amount from the recipient.

(d) When non-payment of the shelter allowance or client-caused damages, as confirmed by a pre-tenancy inspection and post-tenancy inspection or survey conducted by the social services district or by some other means of verifying that the damages were caused by the recipient pursuant to paragraph (2) of subdivision (c) of this section necessitates the authorization of finders' or brokers' fees, or household moving expenses, such payments must be considered to be overpayments made to the recipient and as such, must be recovered according to the provisions of section 352.31(d) of this Part. If rent has not been paid due to a legitimate landlord/tenant dispute, a rent strike or as a result of the application of Section 143-b of the Social Services Law, such payments are not overpayments and cannot be recouped or recovered.

(e) Unless prohibited by State or federal law or regulation, an allowance for expenses, not otherwise authorized under this title, for the repair, maintenance or retention of housing occupied by, but not owned by, a recipient of public assistance must be paid when necessary for the health and safety of the recipient and his or her family, when other appropriate housing is not available and when the payment is necessary to permit the recipient and his or her family to remain in the housing. An allowance for expenses for

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repair and maintenance must be paid only when the owner of the housing is not obligated to provide the repair or maintenance. An allowance under this subdivision does not include payments for utility deposits for gas and electricity, payments covered under subdivision (b) of this section, payments for rent, property taxes or mortgage arrears and payments for litigation costs of any kind, including attorney's fees.

(f) An allowance for storage of furniture and personal belongings must be made when it is essential, for circumstances such as relocation, eviction or temporary shelter, so long as eligibility for public assistance continues and so long as the circumstances necessitating the storage continue to exist.

**352.7 Allowances and grants for other items of need.**

(a) **Furnishings.**

(1) If provision therefor cannot otherwise be made, each social services district must provide for the purchase of necessary and essential furniture, furnishings, equipment and supplies required for the establishment of a home for persons in need of public assistance. For purposes of this subdivision, such an allowance must be provided only when, in the judgment of the social services official, one of the following conditions exists:

(i) An individual or family temporarily housed in a hotel, motel, homeless shelter, residential program for victims of domestic violence or other temporary accommodation to which the individual or family has been referred by the social services district is being permanently rehoused in unfurnished housing accommodations, and suitable furnished accommodations are not available.

(ii) An unattached individual, whose needs cannot otherwise be met under Part 397 of this Title, is discharged from an institution, is determined to be capable of maintaining an apartment in the community, and suitable furnished accommodations are not available.

(iii) An adult, whose needs cannot otherwise be met under Part 397 of this Title, is discharged from an institution and wishes to rejoin his family, which is in need of additional furniture to provide adequate shelter for him.

(iv) A child is returned to his parents, who are in need of additional furniture to provide adequate shelter for him.

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(v) An individual's or family's living situation adversely affects the physical and mental health of that individual or family, and it is essential that the individual or family be rehoused in unfurnished housing accommodations in order to safeguard his or their health, safety and well-being.

(2) An allowance provided under paragraph (1) of this subdivision may not exceed the amounts authorized for the appropriate rooms and items in the following schedule:

**SCHEDULE SA-4a  
INITIAL OR REPLACEMENT COST OF ESSENTIAL  
HOUSEHOLD FURNITURE, FURNISHINGS, EQUIPMENT AND SUPPLIES**

Living room	\$182
Bedroom	
with a single bed	\$145
with two single beds	\$205
with double bed	\$184
Kitchen	
(excluding appliances)	\$142 (plus \$12 for each additional person)
Range	\$182
Refrigerator	\$182 (or \$258 for four or more persons)
Bathroom	\$ 6 (plus \$4 for each additional person) Other
equipment	
Cabinet for linens	\$ 22
Stove for heating	\$ 72 (or \$82 for five or more persons)

(3) Documentation of the need for such furniture must be fully recorded in each case record.

(b) Equipment repairs. Each social services district must provide for the essential repair of heating equipment, cooking stoves and refrigerators used by persons in need of public assistance in their homes, provided provision therefor cannot otherwise be made except that replacement may be authorized when less expensive than repair. Such allowances for cooking stoves and refrigerators cannot exceed the amounts authorized under schedule SA-4a.

(c) Additional cost of meals. Each social services district must provide for the additional costs of meals for persons unable to prepare meals at home or who do not otherwise receive meals in their residences in accordance with the following schedule:

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**SCHEDULE SA-5  
RESTAURANT ALLOWANCE  
SCHEDULE**

Monthly allowances to be added to appropriate monthly grants and allowances for combinations of restaurant meals and meals prepared at home or meals otherwise provided in the residence, including sales tax.

Dinner in a restaurant	\$29.00
Lunch and dinner in a restaurant	\$47.00
All meals in a restaurant	\$64.00

Additional special restaurant allowance as described below.

Effective November 1, 1986, a special monthly restaurant allowance of an additional \$36 must be granted to any pregnant woman or person under 18 years of age, or any person under 19 years of age who is a full-time student regularly attending a secondary school or in the equivalent level of vocational or technical training if, before such person attains age 19, such person may reasonably be expected to complete the program of such secondary school or training.

**HOME DELIVERED MEALS**

Monthly allowances to be added to appropriate monthly grants and allowances.

Extra allowance	\$36.00
-----------------	---------

(d) Replacement of clothing or furniture. Each social services district must provide for partial or total replacement of clothing or furniture which has been lost in a fire, flood or other like catastrophe, provided such needs cannot otherwise be met through assistance from relatives or friends or from other agencies or other resources. Such allowances must not exceed the amounts authorized under schedules SA-4a and SA-4b.

**SCHEDULE SA-4b  
REPLACEMENT COST OF CLOTHING**

Birth through 5 years	\$48.00
6 through 11 years	\$73.00
12 through adult	\$89.00

(e) Reserved.

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(g) Payment for services and supplies already received. Assistance grants must be made to meet only current needs. Under the following specified circumstances payment for services or supplies already received is deemed a current need:

(1) Replacement of lost or stolen checks.

(i) If an applicant or recipient reports to a local social services official that a check has been lost or stolen, an affidavit of loss must be required of the recipient, and payment of the check must be stopped. If the recipient has not already done so, he must be required by the local social services official to report the loss or theft to the police, to obtain from them the blotter entry number, or classification number, or file number or other available evidence of the reporting, and to furnish such evidence to the local social services official. When satisfied that such police report has been made, the local social services official must issue a replacement check to the recipient, on which there must appear above the place for the recipient's signature, the following: "By endorsing or cashing this check I acknowledge that this is a replacement for a check, number dated drawn to my order on which was lost/stolen; that I have not received the proceeds of said check directly or indirectly; and that I have been informed it is illegal for me to cash said check, and if I do so, I am liable to prosecution."

(ii) If payment is not stopped on the original check and it and the replacement check are both cashed, only one must be subject to State reimbursement, and the social services district must limit its claim for State reimbursement to one of the two checks.

(iii) If it is established that a recipient endorsed and cashed an allegedly lost or stolen check which has been replaced, the amount of such check must be recovered from the recipient as provided for by the provisions of the regulations of this department.

(2) Replacement of electronic benefits. When a recipient claims that he or she has not received electronic cash public assistance benefits which the Department's computer issuance record indicates were issued, the social services district must verify the validity of the computer issuance record in accordance with procedures established by the Department. If it is verified that a valid issuance transaction occurred, the benefits cannot be replaced. If it is determined that a valid issuance transaction did not occur, the benefits must be restored in accordance with section 352.31(f) of this Part.

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- (3) A grant may be made to pay for rent, property taxes or mortgage arrears for the time prior to the month in which the public assistance case was opened or for applicants for emergency assistance under Parts 370 and 372 of this Title only when:
- (i) such payment is essential to forestall eviction or foreclosure and no other shelter accommodations are available; or
  - (ii) the health and safety of the applicant is severely threatened by failure to make such payment; and
  - (iii) the authorization for the payment receives special written approval by the social services official or such other administrative officer as he or she may designate, provided such person is higher in authority than the supervisor who regularly approves authorization.
  - (iv) the applicant reasonably demonstrates an ability to pay shelter expenses, including any amounts in excess of the appropriate local agency maximum monthly shelter allowance, in the future. However, when in the judgment of the local social services official, the individual or family has sufficient income or resources to secure and maintain alternate permanent housing, shelter arrears need not be paid to maintain a specific housing accommodation;
  - (v) such payment does not exceed the local agency maximum monthly shelter allowance. A district may, consistent with subparagraph (iv) of this paragraph, issue a grant for arrears in excess of the maximum monthly shelter allowance. However, any amount above the local agency maximum monthly shelter allowance paid towards the monthly arrears is an overpayment subject to recovery and recoupment in accordance with section 352.31 of this Part;
  - (vi) the applicant, if accepted for on-going public assistance, agrees to future restriction of shelter payments in accordance with Part 381 of this Title; and
  - (vii) in the case of an applicant who is not eligible for Safety Net Assistance, Family Assistance, Emergency Assistance to Families, or Emergency Assistance to Adults, such applicant is without income or resources immediately available to meet an emergency need, such applicant's gross household income at the time of application does not

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exceed 125 percent of the federal income official poverty line as defined and annually revised by the Federal Office of Management and Budget, and such applicant signs an agreement to repay the assistance in a period not to exceed 12 months from receipt of such assistance. The repayment agreement must set forth a schedule of payments that will assure repayment within the 12 month period, and must specify the frequency of the payments, the due date of the first payment, the address where payments must be made and the consequences of failing to repay the assistance as agreed. Subsequent assistance to pay arrears may not be granted unless there are not past-due amounts owed under any such repayment agreement. The social services district, in addition to any rights it has pursuant to the Social Services Law, may enforce the repayment agreement in any manner available to a creditor.

(4) A recipient of family assistance or safety net assistance who is threatened with eviction or foreclosure or who is being evicted or whose property is being foreclosed upon for non-payment of rent, mortgage or taxes incurred during a period for which a grant had been previously issued to the recipient may be provided with an advance allowance for rent, mortgage principal and interest payments or taxes in accordance with section 352.11 of this Part. Advance investigation of the need for restricted payments must be conducted in accordance with Part 381 of this Title. An allowance for rent, mortgage principal and interest payments or taxes which exceeds the appropriate local agency maximum monthly shelter allowance can be made only if all of the following conditions are met:

(i) notwithstanding section 352.23(b) of this Part, the recipient agrees to use all available liquid resources for the payment of shelter expenses necessary to prevent eviction or foreclosure;

(ii) the recipient demonstrates an ability to pay shelter expenses in the future, including any amounts in excess of the appropriate local agency maximum monthly shelter allowance;

(iii) the recipient agrees to future restriction of rent or mortgage payments; and

(iv) the recipient has not previously received an allowance pursuant to this paragraph and, subsequent to receiving such allowance, requested discontinuation of restriction of the shelter payments to which he or she agreed pursuant to this paragraph.

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(h) Chattel mortgages or conditional sales contracts. If the furniture or household equipment of an applicant, who has not been a recipient of public assistance within the previous six months preceding his application, is essential to making his living accommodations habitable but are presently encumbered by a chattel mortgage or a conditional sales contract, every effort must be made to defer, cancel or reduce payments on such chattel mortgage or conditional sales contract. If all such efforts fail, an allowance may be made for a compromise settlement of such payments or, if a compromise cannot be reached, for other essential payments; provided, however, that the compromise settlement or allowances must not exceed the cost of replacement.

(i) Camp fees. When funds cannot be obtained from other sources, camp fees may be paid for children receiving FA not in excess of total cost of \$400 per child per annum, in amounts not to exceed \$200 per week.

(j) Reserved.

(k) Additional needs because of pregnancy. A monthly allowance of \$50 must be added to the appropriate monthly grant and allowance of a needy pregnant woman beginning with the fourth month of pregnancy or the month in which medical verification of the pregnancy is presented to the district, whichever is later.

(l) Reserved.

(m) Supplemental payments. The social services official must provide a monthly allowance to supplement the income of an FA, SNA or VA household when the household experiences a net loss of cash income due to the acceptance of employment by a JOBS participant who is a member of the household, when such acceptance is required by the social services district. A net loss of cash income occurs when the monthly gross income of the household, subtracting necessary actual work-related expenses, is less than the cash assistance the household received in the month in which the offer of employment was made. The supplement must equal the monthly net loss of cash income that would occur if the supplement were not paid to the household.

(1) Gross income includes, but is not limited to, earnings, unearned income and cash assistance.

(2) Cash assistance means the budget deficit as defined in section 352.29 of this part.

(3) Necessary actual work-related expenses are the actual, verifiable and unreimbursed expenses directly related to maintaining employment.

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- (i) Such expenses include, but are not limited to:
- (a) mandatory payroll deductions such as federal, State and local taxes, social security taxes, disability insurance and union dues;
  - (b) tools, materials, uniforms and other special clothing required for the job;
  - (c) mandatory fees for licenses or permits fixed by law;
  - (d) deductions for medical insurance coverage;
  - (e) child care up to the local market rate; and
  - (f) transportation, including the cost of transporting children to and from day care, except that the amount for use of a motor vehicle must be computed on a mileage basis at the same rate paid to employees of the social services district and must only be allowed when public transportation is not available.
- (ii) Such expenses do not include:
- (a) meals;
  - (b) business-related depreciation;
  - (c) personal business and entertainment expenses;
  - (d) personal (not work related) transportation;
  - (e) purchase of capital equipment; and
  - (f) payments of the principal of loans.
- (n) Burials. Allowances must be made for burial of applicants for and recipients of public assistance in accordance with section 141 of the Social Services Law.
- (o) Removals. Allowances must be made to applicants for or recipients of public assistance who are removed to another state or country in accordance with section 310.1(h) of this Title. Such allowances can only be made for the reasonable and necessary expenses of such removals, as authorized by section 310.1(h)(2) of this Title.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York

INCOME ELIGIBILITY LEVELS

A. Mandatory Categorically Needy (Continued)

- 3. Children under Section 1902 (a) (10) (i) (VI) of the Act who have attained age 1 but have not attained age 6:

Effective April 1, 1990 based on 133 percent of the official Federal income poverty level (as revised annually in the Federal Register for the size family involved).\*

<u>Family Size</u>	<u>Income Level</u>
[ <u>1</u> ]	\$ <u>12,383</u>
[ <u>2</u> ]	\$ <u>16,612</u>
[ <u>3</u> ]	\$ <u>20,842</u>
[ <u>4</u> ]	\$ <u>25,071</u>
[ <u>5</u> ]	\$ <u>29,300</u>
[ <u>6</u> ]	\$ <u>33,530</u>
[ <u>7</u> ]	\$ <u>37,759</u>
[ <u>8</u> ]	\$ <u>41,989</u>

[For each additional person, add \$4,230.]

\*New York State implemented these provisions effective October 1, 1990.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

INCOME ELIGIBILITY LEVELS (Continued)

A. MANDATORY CATEGORICALLY NEEDY (continued)

4. Children from ages 6 to 19 under the provisions of 1902(l)(2) of the Act.

Based on 100 percent of the official Federal Income Poverty level (as revised annually in the Federal Register for the size family involved.) [\*]

[\* A State Plan amendment was approved under section 1902(r)(2) to allow for a disregard of income between 100% and 133% of the poverty level for children ages 6 to 19.]

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(4) of the Act are as follows:

Based on \_\_\_\_\_ percent of the official Federal income poverty line.

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	\$ _____
<u>2</u>	\$ _____
<u>3</u>	\$ _____
<u>4</u>	\$ _____
<u>5</u>	\$ _____

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

92-27  
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York

INCOME ELIGIBILITY LEVELS (Continued)

C. Qualified Medicare Beneficiaries with Income Related to Federal Poverty Level

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905 (p) (2) (A) of the Act are as follows:

1. Non-Section 1902 (f) States

a. Based on the following percent of the Official Federal Income Poverty Level:

Eff. Jan. 1, 1989: \_\_\_\_\_ 85 percent      100 percent (no more than 100)  
(as revised annually in the Federal Register  
for the size family involved.)

Eff. Jan. 1, 1990: \_\_\_\_\_ 90 percent      \_\_\_\_\_ percent (no more than 100)

Eff. Jan. 1, 1991: 100 percent

Eff. Jan. 1, 1992: 100 percent

[b. Levels:]

<u>Family Size</u>	<u>Income Level</u>
[ <u>1</u> ]	\$ <u>9,310</u>
[ <u>2</u> ]	\$ <u>12,490</u>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York

Income Levels (Continued)

D. Medically Needy

Applicable to all groups.

Applicable to all groups except those specified below. Exempted group income levels are also listed on the attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for ___ months.	Amount by which column (2) exceeds limits specified in 42 CFR 435.1007	Net income for persons living in rural areas for ___ months.	Amount by which column (4) exceeds limits specified in 42 CFR 435.1007
	<input type="checkbox"/> Urban Only <input type="checkbox"/> Urban & Rural			
1	\$ 8,300 *	\$	\$	\$
2	\$ 10,400 *	\$	\$	\$
3	\$ 12,300*	\$	\$	\$
4	\$ 13,300	\$	\$	\$

\* New York is using an income disregard under Section 1902(r)(2) to allow income for households of one, two and three to be up to \$8,700, \$12,800 and \$13,200, respectively.

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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
State: New York

**Income Levels** (Continued)

**D. Medically Needy**

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for ___ months.  ___ Urban Only ___ Urban & Rural	Amount by which column (2) exceeds limits specified in 42 CFR 435.1007	Net income for persons living in rural areas for ___ months.	Amount by which column (4) exceeds limits specified in 42 CFR 435.1007
5	\$ 13,400	\$	\$	\$
6	\$ 13,600	\$	\$	\$
7	\$ 15,300	\$	\$	\$
8	\$ 17,000	\$	\$	\$
9	\$ 18,700	\$	\$	\$
10	\$ 20,400	\$	\$	\$
For each additional Person add	\$ 1,700	\$	\$	\$

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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State: New York

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

The same criteria will be used as applies to transfer of assets.

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is \$           \*

\*there is no maximum value.

**97-25**  
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SUPPLEMENT 11 TO ATTACHMENT 2.6-A  
Page 1  
OMB No.:

State/Territory: New York

Citation

Condition or Requirement

**COST EFFECTIVENESS METHODOLOGY FOR  
COBRA CONTINUATION BENEFICIARIES**

1902(u) of the  
Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods

- The methodology as described in SMM section 3598.  
 Another cost-effective methodology as described below. \*

\* This methodology is described in Attachment 4/22-C of this Plan.

\* See Supplement 11 to Attachment 2.6-A, pages 2 and 3

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TN No. 91-10

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State: New York

**COST EFFECTIVENESS DETERMINATION FOR  
PREMIUM PAYMENTS UNDER THE  
COBRA CONTINUATION COVERAGE PROGRAM**

The determination of cost benefit for any health insurance policy is an evaluation of many varied but interrelated criteria. It is difficult to establish exact guidelines for cost benefit determinations that can be applied uniformly in all cases. Unless a person is already in poor health, whenever insurance is purchased a risk is taken as to whether or not health expenses will be incurred. Therefore, cost benefit determinations must be made on an individual basis after the local district staff obtain insurance policy and the individual applying for the premium payment.

Please note that for some cases, even after reviewing these criteria, the determination to pay for a health insurance policy may still be unclear. In these cases, the final decision will rest solely on the judgement of local district staff.

The following points should be considered in making a determination whether or not to pay insurance premiums within the framework of the COBRA Continuation Coverage Program.

1. Assess the types of medical services covered by the health insurance policies.
2. Has there been a high utilization of medical services by the applicant/recipient (A/R)?

Request the applicant/recipient to bring to the interview all medical bills (paid and unpaid), statements of insurance benefit payments and premium notices for the past year. Determine the total amount paid by all parties for the medical services.

3. Can the past utilization of medical expenses be expected to continue or increase?

During the interview inquire if any acute or chronic medical conditions exist. If so, does the condition require or could it potentially require extensive medical services? Will these potential expenses be covered by the policy?

4. Does a situation exist which warrants maintaining the policy even though there is no history of high medical utilization?

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Supersedes

TN No. **New**

MAR 5 - 1993

Approval Date \_\_\_\_\_

Effective Date JUL 1 - 1991

State: New York

Due to the client's age or a pre-existing condition, is it reasonable to assume that the client may not be able to obtain another policy in the future or that a pre-existing condition would not be covered by a new policy for a period where medical utilization may be expected.

5. For policies in force, what are the maximum benefit levels of the policy?
  - a) Have the maximum benefit levels been met, rendering the A/R nil?
  - b) If so, is the maximum benefit recurring? Will it be reinstated on an annual basis, at the end of a specific benefit period, or does it apply separately to unrelated injuries, sicknesses, and/or conditions?
  - c) If there will be benefits or recurring benefits that will pertain to the A/R's potential medical expenses, how do these benefits compare to the cost of the premium?
6. Review the number of dependents in a family. In general, the larger the family, the more cost beneficial it is to purchase family coverage.
7. Compare the cost of the COBRA premium to the cost of all medical services received by the applicant/recipient in the previous year (see #2). Using this comparison and the other factors related to anticipated future utilization (3 through 6) decide whether or not it is cost beneficial to pay the premium. That is, does the cost of the COBRA premium payment appear likely to be less than the Medicaid expenditures for an equivalent set of services.

NOTE: For those districts that use the "Health Insurance Automated Decision Tree" (HIADT), make sure that the premium payment used in the calculation is the total premium. Under COBRA continuation coverage, the individual (or Medicaid) is generally responsible for both the employer's and employee's share of the insurance premium not to exceed 102% of the applicable premium (or 150% of the premium for disabled individuals beginning in the nineteenth month of coverage). In addition, only use the Medicaid payments for the equivalent set of services that would otherwise be paid for by the insurance policy.

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Resource Policies Permitted Under  
Section 1902(r)(2) of the Social Security Act

Disregard	How More Liberal	Groups Covered	Approved/Protected by
Savings of infants under age 21 of less than \$500	Additional resource is not considered in the determination of eligibility	All MN	Existing State policy since October 1, 1982 & 18 NYCRR 360-4.6(b)(5)
Trust funds of an infant under age 21 of less than \$1000	Additional resource is not considered in the determination of eligibility	All MN	Existing State policy since October 1, 1982
A car - no cap	No limit	All MN	18 NYCRR 360-4.7(a)(2)(iv)
Essential personal property - no cap	No limit	All MN	18 NYCRR 360-4.7(a)(2)
<del>Equity value of income producing property from \$6,000 to \$12,000</del>	<del>Equity value can exceed \$6,000 up to \$12,000</del>	<del>All MN</del>	<del>18 NYCRR 360-4.4(d)</del>
Resource eligibility achieved effective with the first day of the month (including retroactive period) in which resources are reduced to the allowable level.	Federal policy prohibits eligibility for entire month if applicant has excess resources on 12.01 am of the first day of the month. Federal policy also prohibits gaining resource eligibility for retroactive month(s) if excess resources existed in that month.	All MN	Existing State Policy since October 1, 1982

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Resource Policies Permitted Under  
Section 1902(r)(2) of the Social Security Act

Disregard	How More Liberal	Groups Covered	Approved/Protected by
Equity value of income-producing property up to \$12,000	Equity value of up to \$12,000 not considered in the determination of eligibility	ADC-related MN	18 NYCRR 360-4.4
Equity value of nonbusiness income-producing property from \$6,000 to \$12,000	Equity value can exceed \$6,000 up to \$12,000	SSI-related MN	18 NYCRR 360-4.4

TN 91-50

Approval Date NOV 19 1991

Supersedes TN **New**

Date JUL 1 1991

SUPPLEMENT 12, PAGE 2 TO ATTACHMENT 2.6A

NEW YORK STATE

This provision supersedes the resource spend-down provision on Supplement 12, page 1 and all other resource spend-down prohibitions, which were voided by the United States District Court for the Western District of New York in its final order entered on February 6, 1990 and retroactive to January 1, 1982.

Case: Westmiller v. Sullivan

<u>DISREGARD</u>	<u>HOW MORE LIBERAL</u>	<u>GROUPS COVERED</u>	<u>AS APPROVED AND PROTECTED BY</u>
Resource Eligibility achieved effective with the first day of the month (including retroactive period) in which resources are reduced to the allowable level.	Federal policy prohibits eligibility for entire month if applicant has excess resources on 12:01 A.M. of the first day of the month. Federal policy also prohibits gaining resource eligibility for retroactive months(s) if excess resources existed in that month.	All MN	US District Court Order of 2/6/90 retroactive to 1/1/82

- incurred expenses subject to payment by third parties will not be deducted from resources to the same extent that such cannot be deducted in an income spend-down.
- the same incurred medical and remedial care expenses will not be used to meet both income and resources spend-down; and
- the Medicaid program will not pay for any of the incurred expenses used to meet the spend-down of resources provision.

TN 88-35 Approval Date SEP 17 1990

Supersedes TN NEW Effective Date Oct. 1, 1982

RESOURCE POLICIES PERMITTED UNDER  
SECTION 1902(r)(2) OF THE SOCIAL SECURITY ACT

DISREGARD	HOW MORE LIBERAL	GROUPS COVERED	AS APPROVED AND PROTECTED BY
Parental resources of pregnant minors (under 21) living with their parents are disregarded in determining the pregnant minor's eligibility	Parental resources are disregarded	MN Pregnant Women	<u>Woe v. Perales</u>

TN NY 90-58 Approval Date JUL 27 1982  
 Supersedes TN ~~New~~ Effective Date OCT 1 - 1990

**OFFICIAL**

Supplement 12, Page 3 to Attachment 2.6 A

Resource Policies Permitted Under  
Section 1902 (r) (2) of the Social Security Act

Disregard	How More Liberal	Groups Covered	Approved/ Protected by
Resources—no cap for otherwise eligible MA Only recipients who have participated in the NYS Long Term Care Security Demonstration Project (LTC SDP)*	Resources are not considered in the determination of Medicaid eligibility for individuals who have exhausted available private insurance benefits provided by LTC SDP and who are New York State residents at the time of Medicaid application.	All MN	

\* These are long term care policies (LTCP) meeting New York State's guidelines and are available from selected insurance carriers. Policies must guarantee certain LTCP requirements and will carry the Project logo to identify them as meeting the necessary requirements for participation in this public/private partnership. If purchasers exhaust the benefits under the private insurance policy, they will be enrolled in a special State Medicaid program. Under this program, the Medicaid applicant will not be subject to a resource test as usually required under 42 CFR 435.840 and 42 CFR 435.841, and as otherwise specified in New York State's Title XIX State Plan.

TN# 04-39

Approval Date: MAR 23 2005

Supersedes TN#: 91-49

Effective Date: DEC 31 2004

*New*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

The following groups were included in the AFDC State plan effective July 16, 1996:

Pregnant women with no other eligible children.

AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 without modification.

In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, with the following modifications.

The agency applies lower income standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:

The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage

TN 97-38 Approval Date \_\_\_\_\_

Supersedes TN \_\_\_\_\_ Effective Date NOV 1 - 1997

**New**

**OFFICIAL**

Increases in the CPI-U since July 16, 1996, as follows:

— The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

X The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

\*Individual development accounts (IDA) are excluded from resources; interest earned on IDA accounts is excluded from income.

1. \$2,000 disregard for resources
2. Individual development accounts\*
3. 46% of earned income for eligible persons whose family income does not exceed 100% of the federal poverty level. This percentage is disregarded without time limit. The  $30\frac{1}{3}$  disregard will be applied if more advantageous. The percentage disregarded is based on the amount of earned income which must be excluded for a family of three without special needs and without unearned income, living in a heated apartment in the City of New York, to remain eligible until gross income equals the federal poverty level. This percentage will be adjusted on June first of each year to reflect the federal poverty level most recently published in the Federal Register.
4. \$4650 fair market value or \$1500 equity for an automobile

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

1. and 2. are new disregards
3. Enhances  $30\frac{1}{3}$  remainder disregard
4. Enhances equity value of \$1500

— The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

— The agency continues to apply the following waivers of provisions of Part A of title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

TN 99-17 Approval Date SEP 30 1999  
Supersedes TN 97-38 Effective Date APR - 1 1999

DRAFT

Revision: HCFA-PM-00-1 Supplement 12 to Attachment 2.6-A  
February 2000 ADDENDUM

State Plan Under Title XIX of the Social Security Act

State: New York

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

X The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

\_\_\_\_\_ The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

TN 00-09

Supersedes TN New

Approval Date

MAY 18 2000

MAY 18 1998

Effective Date

JAN 1 2000

MAY 18 2000

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

OFFICIAL

State: New York

ELIGIBILITY UNDER SECTION 1925 OF THE ACT  
TRANSITIONAL MEDICAL ASSISTANCE

The State covers low-income families and children for Transitional Medical Assistance (TMA) under section 1925 of the Social Security Act (the Act). This coverage is provided for families who no longer qualify under section 1931 of the Act due to increased earned income, or working hours, from the caretaker relative's employment, or due to the loss of a time-limited earned income disregard. (42 CFR 435.112, 1902(a)(52), 1902(e)(1), and 1925 of the Act)

The amount, duration, and scope of services for this coverage are specified in Section 3.5 of this State plan.

For Medicaid eligibility to be extended through TMA, families must have been Medicaid eligible under section 1931 (months of retroactive eligibility may be used to meet this requirement):

During at least 3 of the 6 months immediately preceding the month in which the family became ineligible under section 1931.

For fewer than 3 of the 6 previous months immediately preceding the month in which the family became ineligible under section 1931. Specify:

The State extends Medicaid eligibility under TMA for an initial period of:

6 months. For TMA eligibility to continue into a second 6-month extension period, the family must meet the reporting, technical, and income eligibility requirements specified at section 1925(b) of the Act.

12 months. Section 1925(b) does not apply for a second 6-month extension period.

The State collects and reports participation information to the Department of Health and Human Services as required by section 1925(g) of the Act, in accordance with the format, timing, and frequency specified by the Secretary and makes such information publicly available.

TN No. 09-48

Supersedes TN No. \_\_\_\_\_

Approval Date \_\_\_\_\_

~~NOV 04 2009~~

Effective Date 7/1/09

Revision: HCFA-PM-97-2  
December 1997

12A  
SUPPLEMENT 12A TO  
ATTACHMENT 2.6-A  
Page 1  
OMB No.: 0938-0673

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: \_\_\_\_\_

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

**98-05**  
TN No. \_\_\_\_\_ Approval Date **MAY 15 1998** Effective Date **JAN 1 1998**  
Supersedes **New**



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.406	<p>3. Is residing in the United States (U.S.), and--</p> <ul style="list-style-type: none"> <li>a. Is a citizen or national of the United States;</li> <li>b. Is a qualified alien (QA) as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as amended, and the QA's eligibility is required by section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended;</li> <li>c. Is a qualified alien subject to the 5-year bar as described in section 403 of PRWORA, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;</li> <li>d. Is a non-qualified alien, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;</li> <li>e. Is a QA whose eligibility is authorized under section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended.  <input checked="" type="checkbox"/> State covers all authorized QAs.  <input type="checkbox"/> State does not cover authorized QAs.</li> <li>f. State elects CHIPRA option to provide full Medicaid coverage to otherwise eligible pregnant women or children as specified below who are aliens lawfully residing in the United States; including the following:</li> </ul>

TN #09-55 \_\_\_\_\_

Approval Date MAR 09 2010

Supersedes TN New

Effective Date APR 01 2009

**OFFICIAL**

**SUPPLEMENT 13 TO  
ATTACHMENT 2.6-A  
Page 2**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York**

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

- (1) A "Qualified alien" otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;
- (2) A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;
- (3) An individual described in 8 CFR section 103.12(a)(4) who does not have a permanent residence in the country of their nationality and is in a status that permits the individual to remain in the U.S. for an indefinite period of time, pending adjustment of status. These individuals include:
  - (a) An individual currently in temporary resident status as an Amnesty beneficiary pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);
  - (b) An individual currently under Temporary Protected Status pursuant to section 244 of the INA;
  - (c) A family Unity beneficiary pursuant to section 301 of Public Law 101-649 as amended by, as well as pursuant to, section 1504 of Public Law 106-554;
  - (d) An individual currently under Deferred Enforced Departure pursuant to a decision made by the President; and
  - (e) An individual who is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and
- (4) An individual in non-immigrant classifications under the INA who is permitted to remain in the U.S. for an indefinite period, including the following as specified in section 101(a)(15) of the INA:
  - A parent or child of an individual with special immigrant status under section 101(a)(27) of the INA, as permitted under section 101(a)(15)(N) of the INA;
  - A Fiancé of a citizen, as permitted under section 101(a)(15)(K) of the INA;
  - A religious worker under section 101(a)(15)(R);
  - An individual assisting the Department of Justice in a criminal investigation, as permitted under section 101(a)(15)(S) of the INA;

**TN #09-55** \_\_\_\_\_

**Approval Date** MAR 09 2009

**Supersedes TN** New

**Effective Date** APR 01 2009

**ORIGINAL**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York**

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

- A battered alien under section 101(a)(15)(U) (see also section 431 as amended by PRWORA); and
- An individual with a petition pending for 3 years or more, as permitted under section 101(a)(15)(V) of the INA.

  X   Elected for pregnant women.  
  X   Elected for children under age  21 .

g.   X   The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA section 214 option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

TN #09-55 \_\_\_\_\_

Approval Date   MAR 09 2010  

Supersedes TN   New  

Effective Date   APR 01 2009

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:           New York State          

ASSET VERIFICATION SYSTEM

1940(a)  
of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.
  - A. The request and response system must be electronic:
    - (1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
    - (2) The system cannot be based on mailing paper-based requests.
    - (3) The system must have the capability to accept responses electronically.
  - B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).
  - C. The system must establish and maintain a database of FIs that participate in the agency's AVS.
  - D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.
  - E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:           New York State          

**OFFICIAL**

ASSET VERIFICATION SYSTEM

2. System Development

A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

B. The agency will hire a contractor to develop an AVS.

In 3 below provide any additional information the agency wants to include.

C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

TN No. 09-49  
Supersedes TN No. NEW

Approval Date MAY 27 2009

Effective Date SEP 30 2009

**OFFICIAL**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York State

ASSET VERIFICATION SYSTEM

- 3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

New York State will work with our contractor to modify the current financial institution match (Financial Institution Recipient Match (FIRM)) to come into compliance with the Asset Verification System (AVS) minimum requirements.

New York State's Financial Institution Recipient Match (FIRM) is a State developed financial institution computer match that provides Local Departments of Social Services (LDSS) with resource information for use in assessing Medicaid and Temporary Assistance eligibility. FIRM is part of the resource file integration (RFI) system. The RFI system also compares applicant/recipients (A/Rs) against individuals on the resource files of various State and Federal agencies in order to verify the information provided by A/Rs on the Medicaid application and renewal forms and to provide additional information to the Medicaid eligibility worker.

TN No. 09-40 Approval Date MAY 27 2009 Effective Date SEP 30 2009  
 Supersedes TN No. NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

Same as SSI resources levels.

Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>No resource test</u>
<u>2</u>	<u>No resource test</u>

b. Optional Groups

Same as SSI resources levels.

Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>No resource test</u>
<u>2</u>	<u>No resource test</u>

81-79B  
TN No. \_\_\_\_\_  
Supersedes \_\_\_\_\_ Approval Date JUN 26 1991 Effective Date OCT 01 1991  
TN No. 87-35A

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

2. Infants

a. Mandatory Group of Infants

Same as resource levels in the State's approved AFDC plan.

Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>No resource test</u>
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____
<u>6</u>	_____
<u>7</u>	_____
<u>8</u>	_____
<u>9</u>	_____
<u>10</u>	_____

91-79B

TN No. \_\_\_\_\_  
Supersedes \_\_\_\_\_  
TN No. 87-35A Approval Date JUN 26 1992 Effective Date OCT 01 1991  
HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

SUPPLEMENT 2 TO ATTACHMENT 2.6-A  
Page 3  
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

b. Optional Group of Infants

Same as resource levels in the State's approved AFDC plan.

Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>No resource test</u>
<u>2</u>	
<u>3</u>	
<u>4</u>	
<u>5</u>	
<u>6</u>	
<u>7</u>	
<u>8</u>	
<u>9</u>	
<u>10</u>	

91-79B

TN No. \_\_\_\_\_  
Supersedes 91-19 Approval Date JUN 26 1992 Effective Date OCT 01 1991  
TN No. \_\_\_\_\_

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

3. Children

a. Mandatory Group of Children under Section 1902(a)(10)(i)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

       Same as resource levels in the State's approved AFDC plan.

X Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>No resource test</u>
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____
<u>6</u>	_____
<u>7</u>	_____
<u>8</u>	_____
<u>9</u>	_____
<u>10</u>	_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

- b. Mandatory Group of Children under Section 1902(a)(10)(i)(VII) of the Act. (Children born after September 30, 1983 who have attained age 6 but have not attained age 19.)

Same as resource levels in the State's approved AFDC plan.

Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>No resource test</u>
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____
<u>6</u>	_____
<u>7</u>	_____
<u>8</u>	_____
<u>9</u>	_____
<u>10</u>	_____

92-27  
TN No. \_\_\_\_\_  
Supersedes Approval Date JAN 20 1993 Effective Date APR 1 - 1992  
TN No. 91-79B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

4. Aged and Disabled Individuals

Same as SSI resource levels.

More restrictive than SSI levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____

Same as medically needy resource levels (applicable only if State has a medically needy program)

TN No. 91-79B  
Supersedes \_\_\_\_\_ Approval Date JUN 26 1992 Effective Date OCT 01 1991  
TN No. NEW HCFA ID: 7985E

**OFFICIAL**

Revision on HCFA-PM-91-4  
August 1991

Supplement 2 to Attachment 2.6-A  
Page 7  
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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**State: New York**

**Resource Levels** (Continued)

**B. Medically Needy**  
Applicable to all groups-

\_\_\_ Except those specified below under the provision of section 1902 (f) of the Act.

<u>Family Sizes</u>	<u>Resource Level</u>
<u>1</u>	\$ <u>4,350</u>
<u>2</u>	\$ <u>6,400</u>
<u>3</u>	\$ <u>6,600</u>
<u>4</u>	\$ <u>6,650</u>
<u>5</u>	\$ <u>6,700</u>
<u>6</u>	\$ <u>6,800</u>
<u>7</u>	\$ <u>7,650</u>
<u>8</u>	\$ <u>8,500</u>
<u>9</u>	\$ <u>9,350</u>
<u>10</u>	\$ <u>10,200</u>

For each additional person \$ 850

TN#: 08-07

Approval Date: OCT 01 2009

Supersedes TN#: 07-19

Effective Date: JAN 01 2008

# OFFICIAL

Revision: HCFA-PM-85-3 (BERC)  
April 2006

SUPPLEMENT 3 TO ATTACHMENT 2.6-A  
Page 1  
OMB NO.: 0938-0193

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

### REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

New York State allows all medical expenses in accordance with  
1902(r)(1)(A)(ii) of the Social Security Act.

The deduction for medical and remedial care expenses that were incurred as  
the result of imposition of a transfer of assets penalty period is limited to zero.

TN#: 06-34

Approval Date: AUG 1 2006

Supersedes TN#: 85-25

Effective Date: APR 01 2006

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM  
THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

91-79B  
TN No. 91-79B Approval Date JUN 26 1992 Effective Date OCT 01 1991  
Supersedes  
TN No. NEW HCFA ID: 7985E

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

SUPPLEMENT 5 TO ATTACHMENT 2.6-A  
Page 1  
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

MORE RESTRICTIVE METHODS OF TREATING RESOURCES  
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

yi-79B

TN No. \_\_\_\_\_  
Supersedes \_\_\_\_\_  
TN No. 85-25

Approval Date JUN 26 1992

Effective Date OCT 01 1991

HCFA ID: 7985E

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

SUPPLEMENT 5a TO ATTACHMENT 2.6-A  
Page 1  
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS  
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

91-79B  
TN No. 91-79B Approval Date JUN 26 1992 Effective Date OCT 01 1991  
Supersedes  
TN No. 87-35A HCFA ID: 7985E

# OFFICIAL

Supplement 6 to Attachment 2.6 A

State: New York

## Standards for Optional State Supplementary Payments

Payment Category	Administered by		Income Level				Income Disregard
			Gross		Net		
	Federal	State	1 person	Couple	1 person	Couple	Employed
(1)	(2)		(3)		(4)		(5)
Reasonable Classification							
Living Alone	X		300% of SSI FBR	300% of SSI FBR	724	1,060	As per CFR 416. Part K
Living w/ others	X		300%	300%	660	1002	300%
Level I Family Care NYC, Nassau, Rockland, Suffolk, Westchester Counties Rest of State	X		300%	300%	903.48	1,806.96	
	X				865.48	1,730.96	
Level II Residential Care NYC, Nassau, Rockland, Suffolk, Westchester Counties Rest of State	X		300%	300%	1,072	2,144	
	X				1,042	2,084	
Level III Enhanced Residential Care NYC, Nassau, Rockland, Suffolk, Westchester Counties and Rest of State	X		300%	300%	1,293	2,586	

TN#: 08-07

Approval Date: OCT 01 2009

Supersedes TN#: 07-19

Effective Date: JAN 01 2000

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

SUPPLEMENT 7 TO ATTACHMENT 2.6-A  
Page 1  
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York

INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY  
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

91-89B  
TN No. \_\_\_\_\_ Approval Date JUN 26 1992 Effective Date OCT 01 1991  
Supersedes \_\_\_\_\_  
TN No. 85-25 HCFA ID: 7985E

Revision: HCFA-PM-91-1 (BPD)  
AUGUST 1991

SUPPLEMENT B TO ATTACHMENT 2.6-A  
Page 1  
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

TN No. 01-79B Approval Date JUN 26 1992 Effective Date OCT 01 1991  
Supersedes  
TN No. 85-25 HCFA ID: 7985E

Revision: HCFA-PM-91-4  
August 1991

(BPD)

SUPPLEMENT 8a to ATTACHMENT 2.6-A  
Page 1  
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**OFFICIAL**

State: New York

**MORE LIBERAL METHODS OF TREATING INCOME  
UNDER SECTION 1902(r)(2) OF THE ACT**

Section 1902(f) State

Non-Section 1902(f) State

Disregard	How More Liberal	Groups Covered	Approved/ Protected by
<p>Income – In determining eligibility for NYSPLTC policyholders* who have satisfied the minimum duration requirements of their policy, disregard an amount of income equal to the Minimum Monthly Maintenance Needs Allowance for a married policyholder, and one-half of that amount for a single individual. This disregard will not be applied during the post eligibility treatment of income process.</p> <p>* These are Partnership qualified long-term care policies meeting New York State's guidelines and are available from selected insurance carriers. Policies must guarantee certain standards and requirements and will carry the project logo to identify them as meeting the necessary standards and requirements for participation in this public/private partnership. If purchasers utilize the minimum required benefits under the private insurance policy, they will be enrolled in a special State Medicaid program. Under this program, the Medicaid applicant either will not be subject to a resource test as usually required under 42 CFR 435.840 and 42 CFR 435.841, and as otherwise specified in New York State's Title XIX State Plan, or will be subject to a more limited resource test different than usually required under 42 CFR 435.840 and 42 CFR 435.841, and as otherwise specified in New York State's Title XIX State Plan that is based on the disregard of an amount of resources equal to the amount of private insurance benefits paid by a selected insurance carrier on behalf of the applicant.</p>	<p>Disregards income otherwise countable under 42 CFR 435.831.</p>	<p>All MN</p>	

HCFA ID: 7985E

TN No.: 09-59  
Supersedes  
TN No. 91-79B

Approval Date DEC 21 2009  
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**OFFICIAL**

Revision: HCFA-PM-91-4  
August

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York State Department of Health

**MORE LIBERAL METHODS OF TREATING INCOME  
UNDER SECTION 1902 (r) (2) OF THE ACT**

Section 1902 (f) State                       Non-Section 1902(f)State

1. Deemed income of parents of pregnant women described in 1902(a)(10)(A)(i)(IV) and 1902 (l)(2) of the Act is disregarded when determining eligibility for pregnant women.
2. In determining eligibility for pregnant women and infants under age 1, as referenced under Section 1902(a)(10)(i)(IV), disregard the difference between 185% and 200% of the Federal Poverty Level by family size as revised annually in the Federal Register.
3. In determining eligibility for children under age 21 who are in the care and custody of the local social services district commissioner or in the care and custody of the Commissioner of the Office of Children and Family Services, as authorized by Sections 1902(a)(10)(A)(ii)(I) and 1905(a)(i) of the Act and by 42 CFR Section 435.222(b)(1) and as described in Attachment 2.2-A, page 13, paragraph B.(b)(1)(d), disregard all income.

**For Medically Needy, New York will use disregard four or five, whichever is more beneficial to the household.**

4. In determining the Medicaid eligibility of persons under Section 1902 (a)(10)(c) of the Social Security Act, disregard monthly income that falls between:
  - the maximum monthly amount that can be paid under Section 1903(f) of the Act (one hundred thirty-three and one-third percent of the highest amount that would ordinarily have been paid to a household of the same size under the aid to families with dependent children program. Maximum monthly amounts are calculated by rounding the annual amounts under each section to the next \$100, then divided by 12) and,
  - the maximum monthly amount that can be paid to AFDC-related groups other than pregnant women and infants described in Supplement 1 to Attachment 2.6(A), page 1, paragraph A,1, multiplied by one hundred thirty-three and one-third percent, rounded to the next \$100.

TN#: 08-07

Approval Date: OCT 01 2009

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Effective Date: JAN 01 2008

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August

(BPD)

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5. In determining the Medicaid eligibility of persons under Section 1902 (a)(10)(c) of the Social Security Act, disregard monthly income that falls between:

The difference between the income limits required by Section 1903(f) of the Act and the combined monthly federal and state income standard for SSI-eligible individuals and couples multiplied by twelve and rounded up to the next highest one hundred dollars.

TN#: 08-07

Approval Date: OCT 01 2007

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Effective Date: JAN 01 2008

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August 1991

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

MORE LIBERAL METHODS OF TREATING INCOME  
UNDER SECTION 1902(e) (2) OF THE ACT

Section 1902(f) State

Non-Section 1902(f) State

The income above the maximum income level of a disabled individual eligible under Section 1902(a) (10) (A) (ii) (xii) and below the State's Medically Needy Income Level is disregarded when determining the eligibility of TB infected individuals for TB related services.

TN No. 94-14   
Supersedes New Approval Date JUL 1 1994 Effective Date JAN 1 - 1994  
TN No. New HCFA ID: 7985E

Revision: HCFA-PM-00-1 Supplement 8A to Attachment 2.6-A  
February 2000 ADDENDUM

State Plan Under Title XIX of the Social Security Act

State: New York

LESS RESTRICTIVE METHODS OF TREATING INCOME  
UNDER SECTION 1902(r)(2) OF THE ACT

X For all eligibility groups not subject to the  
limitations on payment explained in section 1903(f) of the Act\*: All  
wages paid by the Census Bureau for temporary employment related to  
Census 2000 activities are excluded.

- Less restrictive methods may not result in exceeding gross  
income limitations under section 1903(f).

TN 00-09 Approval Date MAY 18 2000  
Supersedes TN New Effective Date JAN 1 2000

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

**OFFICIAL**

**MORE LIBERAL METHODS OF TREATING RESOURCES  
UNDER SECTION 1902(R)(2) OF THE ACT**

Section 1902(f) State  Non-Section 1902(f) State

Disregard	How More Liberal	Groups Covered	Approved/Protected by
Living expenses of infants under age 21 of less than \$500	Additional resource is not considered in the determination of eligibility	All MN	Existing State policy since October 1, 1982 & 18 NYCRR 360-4.6(b) (5)
Trust funds of an infant under age 21 of less than \$1000	Additional resource is not considered in the determination of eligibility	All MN	Existing State policy since October 1, 1982
Car - no cap	No limit	All MN TWWIIA-BC TWWIIA-MI	18 NYCRR 360-4.7(a)(2)(iv)
Essential personal property - no cap	No limit	All MN TWWIIA-BC TWWIIA-MI	18 NYCRR 360-4.7(a)(2)
Equity value of income producing property from \$6,000 to \$12,000	<del>Equity value can exceed \$6,000 up to \$12,000</del>	All MN	<del>18 NYCRR 360-4.4.(d)</del>
Resource eligibility achieved effective with the first day of the month (including retroactive period) in which resources are reduced to allowable level.	Federal policy prohibits eligibility for entire month if applicant has excess resources on 12.01 am of the first day of the month. Federal policy also prohibits gaining resource eligibility for retroactive month(s) if excess resources existed in that month.	All MN TWWIIA-BC TWWIIA-MI	Existing State Policy since October 1, 1982

03-11

Approval Date JUN 26 2003

91-79 B

Effective Date: JUL 01 2003

Supersedes TN

TWWIIA=Ticket to Work and Work Incentives Improvement Act  
TWWIIA BC=Basic Coverage Group  
TWWIIA MI=Medical Improvement Group

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(BPD)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

**MORE LIBERAL METHODS OF TREATING RESOURCES  
UNDER SECTION 1902(R)(2) OF THE ACT**

Section 1902(f) State

Non-Section 1902 (f) State

Disregard	How More Liberal	Groups Coverage	Approved/ Protected by
Equity value of income-producing property up to \$12,000	Equity value of up to \$12,000 not considered in the determination of eligibility	ADC-related MN TWWIA BC TWWIA - MI	18 NYCRR 360-4.4
Equity value of nonbusiness income-producing property from \$6,000 to \$12,000	Equity value can exceed \$6,000 up to \$12,000	SSI-related MN TWWIA BC TWWIA - MI	18 NYCRR 360-4.4

TN 03-111  
Supersedes TN 91-79B

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

MORE LIBERAL METHODS OF TREATING RESOURCES  
UNDER SECTION 1902(f)(2) OF THE ACT

Section 1902(f) State

Non-Section 1902(f) State

Deemed resources of parents of pregnant women described under 1902(a)(10)(A)(i)(IV) and 1902(1) of the Act are disregarded when determining eligibility for pregnant women.

Deemed resources of parents of medically needy pregnant women are disregarded when determining eligibility for pregnant women.

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Supersedes Approval Date JUN 26 1991

Effective Date OCT 01 1991

TN No. NEW

HCFA ID: 7985E

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August 1991

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York  
MORE LIBERAL METHODS OF TREATING RESOURCES  
UNDER SECTION 1902(f)(2) OF THE ACT

Section 1902(f) State

Non-Section 1902(f) State

Disregard	How More Liberal	Groups Covered	Approved/Protected by
1. All [R]resources [no cap] for [otherwise eligible MA-Only recipients who have participated in] a person who exhausts the minimum required benefits under a "total asset protection" long-term care insurance policy approved under the NYS Partnership for Long Term Care [Security Demonstration Project (LTC-SDP)] *	Disregards [R]resources [are not considered in the determination of Medicaid eligibility for individuals who exhausted available private insurance benefits provided by LTC-SDP and who are New York State residents at the time of Medicaid application] otherwise countable under 42 CFR 435.845.	All MN	
2. An amount of resources equivalent to the value of benefits received under a "dollar for dollar" long-term care insurance policy approved under the NYS Partnership for Long Term Care for a person who exhausts the minimum required benefits under such a policy.*	Disregards resources otherwise countable under 42 CFR 435.845.	All MN	
<p>* [These are 1]Long-term care insurance policies [(LTCP) meeting New York State's guidelines and are available from selected insurance carriers. Policies must guarantee certain LTCP requirements and will carry] bearing the [project] logo of the NYS Partnership for Long Term Care have been approved by the NYS Department of Insurance [to identify them] as meeting [the necessary requirements for participation in this public/private partnership. If purchasers exhaust the] minimum benefit[s] standards [under the private insurance policy, they will be enrolled in a special State Medicaid program. Under this program, the Medicaid applicant will not be subject to a resource test as usually required under 42 CFR 435.840 and 42 CFR 435.841, and as otherwise specified in New York State's Title XIX State Plan]. A "total asset protection" policy provides a minimum benefit of at least three years of nursing facility care. A "dollar for dollar" policy provides a minimum benefit of one and a half, but less than three, years of nursing facility care.</p>			

HCFA ID: 7985E

TN#: 04-39

Approval Date: MAR 23 2005

Supersedes TN#: 91-798

Effective Date: DEC 31 2004

*Need*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

MORE LIBERAL METHODS OF TREATING RESOURCES  
UNDER SECTION 1902(f) (2) OF THE ACT

Section 1902(f) State

Non-Section 1902(f) State

The Resource amount above the maximum resource level of a disabled individual eligible under Section 1902(a)(10)(A)(ii)(XII) and below the State's Medically Needy Resource Level is disregarded when determining the MA eligibility of TB infected individuals for TB related services.

IN No. 94-14  
Supersedes Approval Date JUL 1 1994 Effective Date JAN 1 - 1994  
IN No. New HCFA ID: 7985E

**OFFICIAL**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York

**MORE LIBERAL METHODS OF TREATING - RESOURCES  
UNDER SECTION 1902 ( r ) ( 2 ) OF THE ACT**

Section 1902 (f) State  Non-Section 1902(f)  
State

When determining the MA eligibility of Qualified Individuals under Section 1902(a)(10)(E)(iv) of the Act, the resource amounts are to be disregarded.

When determining the eligibility of Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries under the Section 1902 (a) (10) (E) of the Act, the resource amounts are to be disregarded.

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TN No. 08-05 Approval Date AUG 21 2008  
Supersedes TN No. 02-15 Effective Date APR 01 2008

SUPPLEMENT 8b to Attachment 2.6-A

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**OFFICIAL**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACTState: New YorkMORE LIBERAL METHODS OF TREATING - RESOURCES  
UNDER SECTION 1902 (r) (2) OF THE ACT Section 1902 (f) State Non-Section 1902 (f) State

1. In determining eligibility for children under age 21 who are in the care and custody of the local social services district commissioner or in the care and custody of the Commissioner of the Office of Children and Family Services, as authorized by Sections 1902(a)(10)(A)(ii)(I) and 1905(a)(i) of the Act and by 42CFR 435.222(b)(1), and as described in Attachment 2.2-A, page 13, paragraph B.(b)(1)(d), disregard all resources.
2. In determining the Medicaid eligibility of persons under Section 1902 (a)(10)(c) of the Social Security Act, disregard resources that fall between:
  - one half of the annual maximum income amount that can be paid under Section 1903(f) of the Act (one hundred thirty-three and one-third percent of the highest monthly amount that would ordinarily have been paid to a household of the same size under the aid to families with dependent children program, rounded to the next \$100, multiplied by 12); and
  - one half of the annual maximum income amount that can be paid to AFDC-related groups other than pregnant women and infants described in Supplement 1 to Attachment 2.6(A), page 1, paragraph A.1, (one hundred thirty-three and one-third percent of the highest monthly amount multiplied by 12, rounded to the next \$100).

TN#: 05-01BApproval Date: FEB 16 2006JAN 01 2005Supersedes TN#: 05-11

Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW YORK

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a '1915 waiver.

2. Non-institutionalized individuals:

— The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

— The following other long-term care services for which medical assistance is otherwise under the agency plan:

State: NEW YORK

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

the first day of the month in which the asset was transferred;

the first day of the month following the month of transfer.

4. Penalty Period - Institutionalized Individuals--  
In determining the penalty for an institutionalized individual, the agency uses:

the average monthly cost to a private patient of nursing facility services in the agency;

the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period - Non-institutionalized Individuals--  
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

state: NEW YORK

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

does not impose a penalty;

imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

does not impose a penalty;

imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap--

The agency:

totals the value of all assets transferred to produce a single penalty period;

calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap--

The agency:

assigns each transfer its own penalty period;

uses the method outlined below:

State: NEW YORK

TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

- (a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

In the case of a transfer by a spouse of an individual which results in a period of ineligibility for the individual, if the spouse becomes eligible for MA before such period of ineligibility ends, the remaining portion of the period of ineligibility will be divided equally between the individual and the spouse so long as both remain eligible for MA.

- (b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset--  
When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

- X The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

- X For transfers of individual income payments, the agency will impose partial month penalty periods.

- X For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

- The agency uses an alternate method to calculate penalty periods, as described below:

State: New York

TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship—  
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

- The form, "Explanation of the Effect of Transfer of Assets on Medical Assistance Eligibility", is made available to all individuals who request such information and must be given to all MA-only applicants at the time of the initial application. The form must also be sent when an A/R is denied/discontinued due to a prohibited transfer. This form notifies A/R's that an undue hardship provision exists.
- At any time during or after the application process, an A/R or his/her representative may request that a determination based on undue hardship be made. The local district must base its decision on the criteria set forth below. Local districts must determine whether an undue hardship waiver will be granted within 30 days of such a request by an A/R or his/her representative. A longer time period may be allowed in situations where additional time is needed due to difficulties or delays in obtaining evidence.
- The mandated client notice that informs the A/R of his/her denial/discontinuation for MA due to transfer of assets, provides detailed information on the process under which an adverse action determination can be appealed via fair hearing process.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

Undue hardship cannot be claimed; if the client failed to fully cooperate, to the best of his/her ability, as determined by the social services district, in having all of the transferred assets returned or the trust declared void (where possible). Cooperation may include but is not limited to, assisting in providing all legal records pertaining to the transfer creation of the trust, assisting the district, wherever possible, in providing information regarding the transfer amount, to whom it was transferred, any documents to support the transfer or any other information related to the circumstances of the transfer; or

Additionally, undue hardship cannot be claimed when after payment of medical expenses, the individual's or couple's income and/or resources is above the allowable MA exemption standard for a household of the same size; or

when the only result is the individual's or the individual's spouse claim that the assets are needed to maintain a pre-existing life style; or

when application of the transfer of assets provision merely causes

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Supersedes		
TN No. <u>New</u>		

State: New York

## TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship—  
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

(continued from previous page)

Fair hearings are provided pursuant to federal regulations (Goldberg v. Kelly)

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

(continued from previous page)

the individual inconvenience; or

when such application might restrict his or her lifestyle but would not put him/her at risk of serious deprivation.

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TN No. New

**OFFICIAL**

SUPPLEMENT 9(b) to ATTACHMENT 2.6-A

Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

TRANSFER OF ASSETS

1917(c) FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

Nursing facility services;

Nursing facility level of care provided in a medical institution;

Home and community-based services under a 1915(c) or (d) waiver.

2. Non-institutionalized individuals:

— The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

TRANSFER OF ASSETS

than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a) (7));

Home and community care for functionally disabled elderly adults (section 1905(a) (22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a) (24).

The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

\_\_\_\_ The State uses the first day of the

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**OFFICIAL**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

TRANSFER OF ASSETS

month in which the assets were transferred

X The State uses the first day of the month after the month in which the assets were transferred

or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

4. Penalty Period - Institutionalized Individuals--  
In determining the penalty for an institutionalized individual, the agency uses:

\_\_\_ the average monthly cost to a private patient of nursing facility services in the State at the time of application;

X the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period - Non-institutionalized Individuals--

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

TRANSFER OF ASSETS

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

— imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care--

X Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

X The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income--

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

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OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

TRANSFER OF ASSETS

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

X For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

X For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

9. Imposition of a penalty would work an undue hardship--

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

- (a) Of medical care such that the individual's health or life would be endangered; or
- (b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

- (a) Notice to a recipient subject to a penalty

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

TRANSFER OF ASSETS

that an undue hardship exception exists;

- (b) A timely process for determining whether an undue hardship waiver will be granted; and
- (c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

\_\_\_\_\_ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed \_\_\_\_\_ days (may not be greater than 30).

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SUPPLEMENT 9(b) to ATTACHMENT 2.6-A  
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

TRANSFER OF ASSETS

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

TRANSFER OF RESOURCES \*

1902(f) and 1917  
of the Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in section 1613(c) of the Social Security Act (Act).

1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

a.  The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds \$12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

Where the UCV is more than \$12,000, the time limit for consideration of the UCV amount toward resources shall be extended for one month for each additional \$2,000 in excess of the \$12,000.

The amount of the UCV may be diminished by an amount equal to the amount of medical expenses incurred in this period.

\*The State is in compliance with the transfer of assets provision of the MCCA as amended by the Family Support

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TN No. 85-25

Act and OBRA, 1989.  
Approval Date

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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- b.  The period of ineligibility is less than 24 months, as specified below:

Where the UCV is \$12,000 or less the UCV amount must be counted towards the resource limit for a period of 24 months from the date of the transfer, or until the amount of medical expenses equals the UCV.

- c.  The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.

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Supersedes  
TN No. 85-25

Approval Date JUN 26 1992

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AUGUST 1991

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2. Transfer of the home of an individual who is an inpatient in a medical institution.

X A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917(c)(2)(B)(i).

- a. Subject to the exceptions on page 2 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

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AUGUST 1991

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- b.  Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

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No individual is ineligible by reason of item A.2 if--

- (i) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;
- (ii) Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;
- (iii) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or
- (iv) The agency determines that denial of eligibility would work an undue hardship.

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3. 1902(f) States

1 Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is \$12,000 or less:

2. If the uncompensated value of the transfer is more than \$12,000:

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3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

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TN No. 85-25 HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	<b>A. <u>General Conditions of Eligibility</u></b>
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
1902(l) of the Act	(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

State: New York

Citation	Condition or Requirement
1905(p) of the Act	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435. c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.402	3. Is residing in the United States and-- a. Is a citizen; b. Is an alien lawfully admitted for permanent residence or otherwise permanently residing in the Nationality Act United States under color of law, as defined in 42 CFR 435.408;
1902(a) and 1903(v) of the Act and 245A(h)(3)(B) of the Immigration & Nationality Act	c. Is an alien granted lawful temporary resident status under section 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind, or disabled as defined in section 1614(a)(1) of the Act, under 18 years of age or a Cuban/Haitian entrant as defined in section 501(e)(1) and (2)(A) of P.L. 96-422;

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TN No. \_\_\_\_\_  
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TN No. 87-35A Approval Date MAR 11 1992 Effective Date OCT 1 1991  
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Citation	Condition or Requirement
42 CFR 435.403 1902(b) of the Act	<p>d. Is an alien granted lawful temporary resident status under section 210 of the Immigration and Nationality Act not within the scope of c. above (coverage must be restricted to certain emergency services during the five-year period beginning on the date the alien was granted such status); or</p> <p>e. Is an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (coverage must be restricted to certain emergency services).</p> <p>4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.</p>
	<p><input checked="" type="checkbox"/> State has interstate residency agreement with the following States: Georgia</p>
	<p><input type="checkbox"/> State has open agreement(s).</p>
	<p><input type="checkbox"/> Not applicable; no residency requirement.</p>

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HCFA ID: 7985E

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Citation	Condition or Requirement
42 CFR 435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program.  <input type="checkbox"/> Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 CFR 433.145 1912 of the Act	6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)

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State/Territory: New York

Citation

Condition or Requirement

An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(1)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

/ Assignment of rights is automatic because of State law.

42 CFR 435.910

7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).

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Citation	Condition or Requirement
1902(c)(2)	8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
1902(e)(10)(A) and (B) of the Act	9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

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TN No. Supersede **New** Approval Date 1991 10 1 Effective Date OCT 1 1991  
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(MB)

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State

Citation(s)	Condition or Requirement
1906 of the Act 10.	Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

U.S. Supreme Court  
Case, New York State  
Department of Social  
Services v. Dublino 11.

Is required to apply for coverage under Medicare Parts A, B and/or D if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state agrees to pay any applicable premiums and cost-sharing (except those applicable under Part D) for individuals required to apply for Medicare. Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.

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December 1997  
State: New York

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Citation	Condition or Requirement
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**B. Posteligibility Treatment of Institutionalized  
Individuals' Incomes**

**1. The following items are not considered in the  
posteligibility process:**

- |                             |   |
|-----------------------------|---|
| 1902(o) of<br>the Act       | a. SSI and SSP benefits paid under §1611(e)(1)(E)<br>and (G) of the Act to individuals who receive care<br>in a hospital, nursing home, SNF, or ICF.  |
| Bondi v<br>Sullivan (SSD)   | b. Austrian Reparation Payments (pension (reparation)<br>payments made under §500 - 506 of the Austrian<br>General Social Insurance Act). Applies only if<br>State follows SSI program rules with respect to<br>the payments. |
| 1902(r)(1) of<br>the Act    | c. German Reparations Payments (reparation payments<br>made by the Federal Republic of Germany).  |
| 105/206 of<br>P. L. 100-383 | d. Japanese and Aleutian Restitution Payments.  |
| 1. (a) of<br>P.L. 103-286   | e. Netherlands Reparation Payments based on Nazi, but<br>not Japanese, persecution (during World War II).   |
| 10405 of<br>P.L. 101-239    | f. Payments from the Agent Orange Settlement Fund<br>or any other fund established pursuant to the<br>settlement in the In re Agent Orange product<br>liability litigation, M.D.L. No. 381 (E.D.N.Y.)                         |
| 6(h)(2) of<br>P.L. 101-426  | g. Radiation Exposure Compensation.   |
| 12005 of<br>P. L. 103-66    | h. VA pensions limited to \$90 per month under<br>38 U.S.C. 5503.   |

**98-05**

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December 1997

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State: New York

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Citation	Condition or Requirement
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1924 of the Act  
435.725  
435.733  
435.832

2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:

Personal Needs Allowance (PNA) of not less than \$30 For Individuals and \$60 For Couples For All Institutionalized Persons.

a. Aged, blind, disabled:  
Individuals \$ 50<sup>1</sup>  
Couples \$ 100<sup>2</sup>

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

b. AFDC related;  
Children \$ 50<sup>1</sup>  
Adults \$ 100<sup>2</sup>

For the following persons with greater need:

Supplement <sup>12-A</sup>12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

c. Individual under age 21 covered in the plan as specified in Item B. 7. of Attachment 2.2-A.  
\$ 50<sup>1</sup>

1. \$35 if person is not in an Article 28 Facility.  
2. \$70 if person is not in an Article 28 Facility.

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TN No. NEW

State: New York

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Citation	Condition or Requirement
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For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

1924 of the Act

3. In addition to the amounts under item 2. , the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:

a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.

         The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.

         The poverty level component is calculated using a percentage greater than the applicable percentage, equal to         %, of the official poverty level (still subject to maximum maintenance needs standard).

  X   The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

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Citation	Condition or Requirement
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In determining any excess shelter allowance, utility expenses are calculated using:

- \_\_\_\_\_ the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or
- \_\_\_\_\_ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

  x   one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B) ) exceeds the dependent family member's monthly income.

\_\_\_\_\_ a greater amount calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1):

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

- (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.
- (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

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State: New York

Citation	Condition or Requirement
<u>  x  </u>	Amount for maintenance of home is: \$ <u>medically needy</u> level for one in Supplement 1
<u>      </u>	Amount for maintenance of home is the actual maintenance costs not to exceed \$ <u>      </u> .
<u>      </u>	Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.
<u>      </u>	Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	<p data-bbox="636 447 1039 483"><u>C. Financial Eligibility</u></p> <p data-bbox="699 499 1536 718">For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below.</p> <p data-bbox="699 741 1552 877">For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.</p> <p data-bbox="699 905 1552 1234"><u>Supplement 1 to ATTACHMENT 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.</u></p>

State: New York

Citation	Condition or Requirement
<input checked="" type="checkbox"/>	<u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
<input type="checkbox"/>	<u>Supplement 7 to ATTACHMENT 2.6-A</u> specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
<input type="checkbox"/>	<u>Supplement 4 to ATTACHMENT 2.6-A</u> specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
<input type="checkbox"/>	<u>Supplement 5 to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
<input checked="" type="checkbox"/>	<u>Supplement 8a to ATTACHMENT 2.6-A</u> specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
<input checked="" type="checkbox"/>	<u>Supplement 8b to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.

91-78

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435.721  
435.831  
and 1902(m)(1)(B)  
and (m)(4) of  
the Act,  
P.L. 99-509  
(Secs. 9402(a)  
and (b))

a. Except as specified under item C.1.e. below, in determining countable income for AFDC related individuals, the disregards and exemptions in the State's approved AFDC plan are applied.

b. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal nonfarm poverty line described in section 1902(m)(1) of the Act, the following disregards are applied:

The disregards of the SSI program. \*

The disregards of the State supplementary payment program, as follows:

The disregards of the SSI program, except for the following restrictions, applied under the provisions of section 1902(f) of the Act:

\* Except for the less restrictive disregards as specified in Supplement <sup>11</sup> to Attachment 2.6A of the State Plan Amendment 85-25.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(z)(2) of the Act	1. <u>Methods of Determining Income</u> a. <u>AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</u> (1) In determining countable income for AFDC-related individuals, the following methods are used: ___ (a) The methods under the State's approved AFDC plan only; or <u>X</u> (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u> (2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) the Act	(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. <u>Aged individuals.</u> In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used:  <input checked="" type="checkbox"/> The methods of the SSI program only.  <input type="checkbox"/> The methods of the SSI program and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>

Citation	Condition or Requirement	87 3
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c. In determining countable income for blind individuals, the following disregards are applied:

- The disregards of the SSI program. \*
- The disregards of the State supplementary payment program, as follows:

- The disregards of the SSI program, except for the following restrictions applied under the provisions of section 1902(f) of the Act.

435.721  
435.831  
and 1902(m)(1)(B)  
and (m)(4) of  
the Act,  
P.L. 99-509  
(Secs. 9402(a)  
and (b))

d. In determining countable income for disabled individuals, including disabled individuals with incomes up to the Federal nonfarm poverty line described in section 1902(m)(1) of the Act the following disregards are applied:

- The disregards of the SSI program. \*

† Except for less restrictive disregards as specified in Supplement <sup>11</sup> to Attachment 2.6A of the State Plan Amendment 85-25.

TN No. 87-35  
Supersedes  
TN No. 85-25

Approval Date DEC 5 1991

Effective Date JUL - 1 1987

HCFA ID: 1038P/0015P

State: New York

Citation	Condition or Requirement
<input type="checkbox"/>	For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> ; and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
<input type="checkbox"/>	For institutional couples, the methods specified under section 1611(e)(5) of the Act.
<input type="checkbox"/>	For optional State supplement recipients under \$435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> .
<input type="checkbox"/>	For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--  — SSI methods only.  — SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .  — Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

01-78  
TN No. 01-78  
Supersedes  
TN No. 87-35A

Approval Date MAR 11 1992

Effective Date OCT 1 1991

HCFA ID: 7985E

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Citation

Condition or Requirement

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1902(1)(3)(E)  
of the Act,  
P.L. 99-509  
(Sec. 9401(b))

e. For pregnant women and infants or children covered under the provisions of section 1902(a)(10)(A)(ii)(IX) of the Act--

(1) In determining countable income, the following disregards and exemptions are those in the State's approved AFDC plan; or those in the State's approved title IV-E plan, as appropriate.

1902(e)(6) of  
the Act,  
P.L. 99-509  
(Sec. 9401(d))

X (2) The agency continues to treat women eligible under the provisions of section 1902(a)(10)(A)(ii)(IX) of the Act as eligible, without regard to any changes in income of the family of which she is a member, until the end of the 60-day period beginning on the last day of her pregnancy.

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TN No. 90-3  
Supersedes  
TN No. NEW

Approval Date MAY 14 1980

Effective Date JAN 01 1980

HCFA ID: 1038P/0015P

State: New York

Citation	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	<p>c. <u>Blind individuals</u>. In determining countable income for blind individuals, the following methods are used:</p> <p>___ The methods of the SSI program only.</p> <p><u>X</u> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.</p> <p>___ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u>, and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.</p> <p>___ For institutional couples, the methods specified under section 1611(e)(5) of the Act.</p> <p>___ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u>.</p> <p>___ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1615 or 1634 agreements--</p> <p>___ SSI methods only.</p> <p>___ SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.</p> <p>___ Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.</p>

TN No. 91-78

Supersedes

TN No. 87-35A

Approval Date

MAR 14 1992

Effective Date

OCT 1 1991

HCFA ID: 7985E

State: New York

Citation	Condition or Requirement
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	<p data-bbox="609 394 1461 527">In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</p> <p data-bbox="560 552 1234 714">d. <u>Disabled individuals.</u> In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:</p> <ul style="list-style-type: none"><li data-bbox="609 741 1201 768">___ The methods of the SSI program.</li><li data-bbox="609 789 1396 873"><u>X</u> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></li><li data-bbox="609 900 1445 957">___ For institutional couples: the methods specified under section 1611(e)(5) of the Act.</li><li data-bbox="609 982 1461 1087">___ For optional State supplement recipients under \$435.230: income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A.</u></li><li data-bbox="609 1115 1461 1327">___ For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A;</u> and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></li></ul>

91-78

TN No. \_\_\_\_\_ Approval Date MAR 11 1992 Effective Date OCT 1 1991  
Supersedes \_\_\_\_\_  
TN No. 88-1 HCFA ID: 7985E

State: NEW YORK

Citation	Condition or Requirement
	For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
	SSi methods only.
	SSi methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>
	Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

91-78  
TN No. \_\_\_\_\_ Approval Date MAR 11 1992 Effective Date OCT 1 1991  
Supersedes \_\_\_\_\_  
TN No. 87-35A HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3)(E) and 1902(r)(2) of the Act	<p>e. <u>Poverty level pregnant women, infants, and children.</u> For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act--</p> <p>(1) The following methods are used in determining countable income:</p> <p>— The methods of the State's approved AFDC plan.</p> <p>— The methods of the approved title IV-E plan.</p> <p><u>X</u> The methods of the approved AFDC State plan and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p> <p>— The methods of the approved title IV-E plan and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p>

92-27  
TN No. 92-27 Approval Date JAN 20 1993 Effective Date APR 1 - 1992  
Supersedes  
TN No. 91-78

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(e)(6) of the Act	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.  (3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	f. <u>Qualified Medicare beneficiaries.</u> In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used:  <input checked="" type="checkbox"/> The methods of the SSI program only.  <input type="checkbox"/> SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>  <input type="checkbox"/> For institutional couples, the methods specified under section 1611(e)(5) of the Act.

State: New York

Citation

Condition or Requirement

If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, after the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.

1905(s) of the Act

9. (1) Qualified disabled and working individuals.

In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.

1905(p) of the Act

(2) Specified low-income Medicare beneficiaries.

In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

TN No.

93-27

Supersedes

92-27

Approval Date

SEP 14 1993

Effective Date

APR 1 1993

State/Territory: New York

Citation

Condition or Requirement

1902(u)  
of the Act

(h) COBRA Continuation Beneficiaries

In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:

X The disregards of the SSI program;

       The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

NOTE: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

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Supersedes New  
TN No.       

Approval Date MAR 11 1992

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HCFA ID: 7985E

**OFFICIAL**

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OMB No.:

Revision:

State/Territory:           New York          

Citation	Condition or Requirement
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1902(a)(10)(A)  
(ii)(XIII) of the Act

(i)

Working Individuals with Disabilities - BBA  
In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied:

- The methodologies of the SSI program.
- The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A.
- The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.

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State/Territory :           New York          

Citation	Condition or Requirement
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1902(a)(10)(A)  
(ii)(XV) of the Act

(ii)

Working Individuals with Disabilities - Basic Coverage Group - TWWIA

In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied:

The agency does not apply any income or resource standard.

NOTE: If the above option is chosen, no further eligibility-related options should be elected.

The agency applies the following income and/or resource standard(s):

Net available monthly income, using SSI methodology for a one-person or a two-person household, may not exceed 250 percent of the applicable Federal Poverty Level. Countable resources may not exceed \$10,000 for a one-person or a two-person household.

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Page 12e  
OMB NO.:

State/Territory: New York

Citation	Condition or Requirement
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1902(a)(10)(A)  
(ii)(XV) of the Act (cont.)

Income Methodologies

In determining whether an individual meets the income standard described above, the agency uses the following methodologies.

- The income methodologies of the SSI program.
- The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.
- The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

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Citation	Condition or Requirement
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1902(a)(10)(A)  
(ii)(XV) of the Act (cont.)

Resource Methodologies

In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.

Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.

The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.

The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

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OMB NO.:

Revision:

State/Territory: New York

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	<p><input checked="" type="checkbox"/> The agency does not disregard funds in retirement accounts.</p> <p><input checked="" type="checkbox"/> The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.</p> <p><input type="checkbox"/> The agency uses the resource methodologies of the SSI program.</p> <p><input type="checkbox"/> The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.</p>

TN No. 03-11

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Citation	Condition or Requirement
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1902(a)(10)(A)  
(ii)(XVI) of the Act

(iii) Working Individuals with Disabilities –  
Employed Medically Improved Individuals –  
TWWIIA

In determining financial eligibility for employed medically improved individuals under this provision, the following standards and methodologies are applied:

The agency does not apply any income or resource standard.

NOTE: If the above option is chosen, no further eligibility-related options should be elected.

The agency applies the following income and/or resource standard(s):

Net available monthly income, using SSI methodology for a one-person or two-person household, may not exceed 250% of the applicable Federal Poverty Level. Countable resources may not exceed \$10,000 for a one-person or a two-person household.

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Citation	Condition or Requirement
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1902(a)(10)(A)  
(ii)(XVI) of the Act (cont.)

Income Methodologies

In determining whether an individual meets the income standard described above, the agency uses the following methodologies.

- The income methodologies of the SSI program.
- The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.
- The agency uses more liberal income methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A.

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Citation	Condition or Requirement
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1902(a)(10)(A)  
(ii)(XVI) of the Act (cont.)

Resource Methodologies

In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.

Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401 (k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.

The agency disregards funds held employer-sponsored retirement plans, but not private retirement plans.

The agency disregards funds in retirement accounts in a manner other than those listed above. The agency's disregards are specified in supplement 8b to Attachment 2.6-A.

**03-11**

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**OFFICIAL**

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Page 12k  
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State/Territory: New York

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	<p><input checked="" type="checkbox"/> The agency does not disregard funds in retirement accounts.</p> <p><input checked="" type="checkbox"/> The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.</p> <p><input type="checkbox"/> The agency uses the resource methodologies of the SSI program.</p> <p><input type="checkbox"/> The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.</p>

N No. 03-11

Superseded N No. New Approval Date JUN 26 2003

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**OFFICIAL**

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State/Territory:           New York          

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) and 1905(v)(2) of the Act	<p><u>Definition of Employed – Employed Medically Improved Individuals – TWWIA</u></p> <p><u>  X  </u> The agency uses the statutory definition of "employed", i.e., earning at least the minimum wage, and working at least 40 hours per month.</p> <p><u>      </u> The agency uses an alternative definition of "employed" that provides for substantial and reasonable threshold criteria for hours of work, wages, or other measures. The agency's threshold criteria are described below:</p>

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Supersedes        Approval Date   JUN 26 2003  

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State/Territory:           New York          

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act	<p><u>Payment of Premiums or Other Cost Sharing Charges</u></p> <p>For individuals eligible under the BBA eligibility group described in No. 25 on page 23f of Attachment 2.2-A:</p> <p>The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied, are described below:</p>

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State/Territory: New York

Citation

Condition or Requirement

1902(a)(10)(A)(ii)(XIII),  
(XV), (XVI), and 1916(g)  
of the Act (cont.)

For individuals eligible under the Basic Coverage Group described in No. 26 on page 23f of Attachment 2.2-A, and the Medical Improvement Group described in No. 27 on page 23f of Attachment 2.2-A:

**NOTE:** Regardless of the option selected below, the agency **MUST** require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds \$75,000 pay 100 percent of premiums.

- The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income.

The premiums or other cost-sharing charges, and how they are applied, are described on page 12o.

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OMB No.:

State/Territory:           New York          

Citation

Condition or Requirement

Sections 1902(a)(10)(A)  
(ii)(XV), (XVI), and 1916(g)  
of the Act (cont.)

Premiums and Other Cost-Sharing Charges

For the Basic Coverage Group and the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described below.

A person whose net available income is at least 150 percent of the applicable Federal Poverty Level must pay a premium equal to the sum of 3 percent of the person's net earned income and 7.5 percent of the person's net unearned income. No premium shall be required from a person whose net available income is less than 150 percent of the applicable Federal income official Poverty Level.

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JUL 01 2003

HCFA ID:

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Citation	Condition or Requirement	87 35
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(4) Other deductions from income applied under the Medicaid plan.

(5) Required incurred medical and remedial services.

5. Resource Exemptions - Categorically and Medically Needy

a. Except as specified in item C.5.e. below, in determining countable resources for AFDC related individuals, the disregards and exemptions in the State's approved AFDC plan are applied.

1902(a)(10)  
and 1902(m)(1)  
(C) of the Act  
P.L. 97-248  
(Section 137) and  
P.L. 99-509  
(Section 9402)

b. In determining countable resources for aged individuals, including aged individuals with incomes up to the Federal nonfarm poverty line described in section 1902(m)(1) of the Act, the following disregards are applied:

The disregards of the SSI program. \*

The disregards of the SSI program, except for the following restrictions, applied under the provisions of section 1902(f) of the Act:

c. In determining countable resources for blind individuals, the following disregards are applied:

The disregards of the SSI program. \*

The disregards of the SSI program, except for the following restrictions applied under the provisions of section 1902(f) of the Act:

\* Except for less restrictive disregards as specified in Supplement 5 to Attachment 2.6A of the State Plan 85-25. 12.

TN No. 87-35  
Supersedes  
TN No. 8629A

Approval Date DEC 5 1991

Effective Date JUL - 1 1987

HCFA ID: 1038P/0015P

State: New York

Citation	Condition or Requirement
1902(k) of the Act	<p>2. Medicaid Qualifying Trusts</p> <p>In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.</p> <p><input type="checkbox"/> The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. <u>Supplement 10 of ATTACHMENT 2.6-A</u> specifies what constitutes an undue hardship.</p>
1902(a)(10) of the Act	<p>3. Medically needy income levels (MNILs) are based on family size.</p> <p><u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, <u>Supplement 1</u> so indicates.</p>

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TN No. \_\_\_\_\_  
Supersedes \_\_\_\_\_  
TN No. **Now**

Approval Date MAR 18 1991

Effective Date OCT 1 1991

HCFA ID: 7985E

Citation	Condition or Requirement	87 35
1902(a)(10) and 1902(m)(1)(C) of the Act, P.L. 97-248 (Section 137) and P.L. 99-509 (Section 9402)	<p>d. In determining countable resources for disabled individuals, including disabled individuals with incomes up to the Federal nonfarm poverty line described in section 1902(m)(1) of the Act, the following disregards are applied:</p> <ul style="list-style-type: none"><li><input checked="" type="checkbox"/> The disregards of the SSI program. *</li><li><input type="checkbox"/> The disregards of the SSI program, except for the following restrictions applied under the provisions of section 1902(f) of the Act:</li></ul>	
1902(1)(3)(B) of the Act, P.L. 99-509 (Section 9401(b))	<p>e. In determining countable resources of women during pregnancy and during the 60-day period beginning on the last day of pregnancy covered under the provisions of section 1902(a)(10)(A)(ii)(IX) of the Act, the following disregards are applied:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Not applicable. No resource standard is applied.</li><li><input type="checkbox"/> The disregards of the SSI program.</li><li><input type="checkbox"/> The following disregards which are different but not more restrictive than the disregards of the SSI program:</li></ul>	

\* Except for less restrictive disregards as specified in Supplement 3 to Attachment 2.6A of the State Plan 85-25.

TN No. 87-35  
Supersedes  
TN No. 86-29

Approval Date DEC 5 1991

Effective Date JUL - 1 1987

HCFA ID: 1038P/0015P

Revision: HCFA-PH-87-4 (BERC)  
MARCH 1987

ATTACHMENT 2.6-A  
Page 13 (17b-1)  
OMB No.: 0938-0193

Citation	Condition or Requirement
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1902(1)(3)(B) of  
the Act,  
P.L. 99-509  
(Section 9401(b))

e. In determining countable resources of women during pregnancy and during the 60-day period beginning on the last day of pregnancy covered under the provisions of section 1902(a)(10)(A)(ii)(IX) of the Act, the following disregards are applied:

- Not applicable. No resource standard is applied.
- The disregards of the SSI program.
- The following disregards which are different but not more restrictive than the disregards of the SSI program:

TN No. 90-3  
Supersedes  
TN No. NEW

Approval Date MAY 10 1990

Effective Date JAN 01 1990

State: New York

Citation	Condition or Requirement
42 CFR 435.732, 435.831	4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only  a. <u>Medically Needy</u>  (1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either <u>1</u> or <u>6</u> month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.  (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:  (a) Health insurance premiums, deductibles and coinsurance charges.  (b) Expenses for necessary medical and remedial care not included in the plan.  (c) Expenses for necessary medical and remedial care included in the plan.  — Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.

1902(a)(17) of the Act.

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

91-78  
TN No. \_\_\_\_\_  
Supersedes 87-35A Approval Date MAR 11 1992 Effective Date OCT 1 1991  
TN No. \_\_\_\_\_ HCFA ID: 7985E

Revision: HCFA-PM-91-8 (MB)  
October 1991

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Page 14a  
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State/Territory: New York

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Citation	Condition or Requirement
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1903(f)(2) of  
the Act

a. Medically Needy (Continued)

- X (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

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TN No. **91-78**  
Supersedes  
TN No. **New**

Approval Date MAR 11 1982

Effective Date OCT 1 1991

HCFA ID: 7985E/

State/Territory New York

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Citation	Condition or Requirement
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Medically Needy (continued)

1902(a)(17)  
435.831(g)(2)  
436.831(g)(2)

States are permitted to exclude from incurred medical expenses those bills for services furnished more than three months before a Medicaid Application

Yes, the State elects to exclude such expenses.

No, the State does not elect to exclude such expenses.

TN No. 96-20  
Supersedes  
TN No.

Approval date AUG 05 1996

Effective Date APR 01

**New**

State: New York

Citation	Condition or Requirement
42 CFR 435.732	<p data-bbox="574 354 1344 384"><b>b. <u>Categorically Needy - Section 1902 (f) States</u></b></p> <p data-bbox="620 409 1409 514">The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:</p> <ol data-bbox="620 541 1474 1024" style="list-style-type: none"><li data-bbox="620 541 1112 571">(1) Any SSI benefit received.</li><li data-bbox="620 598 1474 730">(2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.</li><li data-bbox="620 758 1474 863">(3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.</li><li data-bbox="620 890 1458 947">(4) Other deductions from income described in this plan at <u>Attachment 2.6-A, Supplement 4.</u></li><li data-bbox="620 974 1437 1024">(5) Incurred expenses for necessary medical and remedial services recognized under State law.</li></ol>
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

**91-78**

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TN No. \_\_\_\_\_  
Supersedes 87-35A Approval Date 1992 Effective Date OCT 1 1991  
TN No. \_\_\_\_\_ HCFA ID: 7985E

Revision: HCFA-PM-91-8 (MB)  
October 1991

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State/Territory: New York

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Citation	Condition or Requirement
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4.b. Categorically Needy - Section 1902(f) States  
Continued

1903(f)(2) of  
the Act

\_\_\_ (6) Spenddown payments made to the State by  
the individual.

NOTE: FFP will be reduced to the extent a State is  
paid a spenddown payment by the individual.

TN No. **91-78**  
Supersede **New**  
TN No. **New**

Approval Date MAR 8 1 1992

Effective Date OCT 1 1991

HCFA ID: 7985E/

State: New York

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Citation	Condition or Requirement
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5. Methods for Determining Resources

- a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).
- (1) In determining countable resources for AFDC-related individuals, the following methods are used:
    - (a) The methods under the State's approved AFDC plan; and
    - (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
  - (2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

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TN No. \_\_\_\_\_ Approval Date MAR 11 1992 Effective Date OCT 1 1991  
Supersedes \_\_\_\_\_  
TN No. 87-35A HCFA ID: 7985E

State: New York

Citation

Condition or Requirement

5. Methods for Determining Resources

1902(a)(10)(A),  
1902(a)(10)(C),  
1902(m)(1)(B)  
and (C), and  
1902(r) of the Act

b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:

The methods of the SSI program.

SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

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TN No.

Supersedes

TN No.

**Now**

Approval Date

1992

Effective Date OCT 1 1991

HCFA ID: 7985E

State: New York

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	<p data-bbox="703 380 1503 485">In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.</p> <p data-bbox="607 514 1315 594">c. <u>Blind individuals.</u> For blind individuals the agency uses the following methods for treatment of resources:</p> <ul style="list-style-type: none"><li data-bbox="656 623 1243 651">— The methods of the SSI program.</li><li data-bbox="656 678 1344 758"><u>X</u> SSI methods and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></li><li data-bbox="656 785 1477 945">— Methods that are more restrictive and/or more liberal than those of the SSI program. <u>Supplement 5 to ATTACHMENT 2.6-A</u> describe the more restrictive methods and <u>Supplement 8b to ATTACHMENT 2.6-A</u> specify the more liberal methods.</li></ul>

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

**91-78**

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TN No. \_\_\_\_\_  
Supersedes \_\_\_\_\_ Approval Date MAY 11 1992 Effective Date OCT 1 1991  
TN No. 88-35 HCFA ID: 7985E

Citation	Condition or Requirement	87 35
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10. Treatment of Income and Resources - Categorically and Medically Needy and Qualified Medicare Beneficiaries

- a. AFDC related individuals (other than under items 9.e. and f. below)

The agency uses the same methodologies for treatment of income and resources as used in the State's approved AFDC State plan.

1902(a)(10)(A),  
1902(a)(10)(C),  
and 1902(m)(1)(B)  
and (C) of the  
Act, P.L. 99-509  
(Section 9402(a))

- b. Aged individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act

X The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate).

— The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to ATTACHMENT 2.6-A.

- c. Blind individuals

X The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate).

— The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act.

\* Except for less restrictive disregards as specified in Supplement 5 to Attachment 2.6A of the State Plan 85-25. 11/2/87

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Supersedes

TN No. **New**

Approval Date DEC 5 1991

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HCFA ID: 1038P/0015P

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Citation	Condition or Requirement
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The methodologies are described in Supplement 5 to ATTACHMENT 2.6-A.

1902(a)(10)(A),  
1902(a)(10)(C),  
and 1902(m)(1)(B)  
and (C) of the  
Act, P.L. 99-509  
(Section 9402(a))

d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act.

x The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate).

— The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to ATTACHMENT 2.6-A.

1902(1)(3)  
of the Act,  
P.L. 99-509  
(Section 9401(b))

e. Individuals who are pregnant women covered under section 1902(a)(10)(A)(ii)(X)(A) of the Act.

(1) Treatment of Income

The agency uses the same methodologies for treatment of income as used under--

— The State's approved AFDC plan.

— The approved title IV-E plan.

(2) Treatment of Resources

— The agency uses the same methodologies for treatment of resources as used in the SSI program.

\* Except for less restrictive disregards as specified in Supplement <sup>11/8/2</sup> 5 to Attachment 2.6A of the State Plan 85-25.

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Supersedes  
TN No. **New**

Approval Date DEC 5 1991

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HCFA ID: 1038P/00158

State: New York

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	<p>d. <u>Disabled individuals, including individuals covered under section 1902(a)(10)(A)(i)(X) of the Act.</u> The agency uses the following methods for the treatment of resources:</p> <ul style="list-style-type: none"><li>— The methods of the SSI program.</li><li>X — SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></li><li>— Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in <u>Supplement 5 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></li></ul> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
1902(1)(3) and 1902(r)(2) of the Act	<p>e. <u>Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(i)(IX)(A) of the Act.</u></p> <p>The agency uses the following methods in the treatment of resources.</p> <ul style="list-style-type: none"><li>— The methods of the SSI program only.</li><li>— The methods of the SSI program and/or any more liberal methods described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></li></ul>

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TN No. \_\_\_\_\_  
Supersede **New** Approval Date MAR 11 1992 Effective Date OCT 1 1991  
TN No. \_\_\_\_\_

HCFA ID: 7985E

State: New York

Citation	Condition or Requirement
	<p>— Methods that are more liberal than those of SSI. The more liberal methods are specified in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p>
	<p><u>X</u> Not applicable. The agency does not consider resources in determining eligibility.</p>
	<p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
1902(1)(3) and 1902(r)(2) of the Act	<p>f. <u>Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.</u></p> <p>The agency uses the following methods for the treatment of resources:</p> <p>— The methods of the State's approved AFDC plan.</p> <p>— Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u></p> <p>— Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p><u>X</u> Not applicable. The agency does not consider resources in determining eligibility.</p>
1902(1)(3)(C) of the Act	
1902(r)(2) of the Act	

**91-78**  
TN No. \_\_\_\_\_  
Superseded **Now**  
TN No. \_\_\_\_\_  
Approval Date MAR 11 1992 Effective Date OCT 1 1991  
HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r)(2) of the Act	g. 1. <u>Poverty level children covered under section 1902(a)(10)(A)(1)(VI) of the Act.</u>  The agency uses the following methods for the treatment of resources:  — The methods of the State's approved AFDC plan.  — Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u>  — Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u>  <u>X</u> Not applicable. The agency does not consider resources in determining eligibility.  In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(1)(3)(C) of the Act	
1902(r)(2) of the Act	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g. 2. <u>Poverty level children under section 1902(a)(10)(A)(i)(VII)</u>  The agency uses the following methods for the treatment of resources:  — The methods of the State's approved AFDC plan.  — Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u>  — Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>  <u>X</u> Not applicable. The agency does not consider resources in determining eligibility.  In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3)(C) the Act	
1902(r)(2) of the Act	

State/Territory: New York

Citation	Condition or Requirement
1905(p)(1) (C) and (D) and 1902(r)(2) of the Act	5. h. <u>For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency use the following methods for treatment of resources:</u>  — The methods of the SSI program only.  <u>X</u> The methods of the SSI program and/or more liberal methods as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u>
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources:  <u>X</u> The methods of the SSI program only.  — More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 Attachment 2.6-A.

TN No. 91-78  
Supersedes

MAR 11 1992

Approval Date

Effective Date

OCT 1 1991

TN No. 87-35A

91-51

HCFA ID: 7985E

State: New York

Citation Condition or Requirement

1902(a)(10)(E)(iii)  
of the Act

k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act--

The agency uses the same method as in 5.h. of Attachment 2.6-A.

6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

- Same as SSI resource standards.
- More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

93-27

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TN No. 91-78 Approval Date SEP 14 1993 Effective Date APR 1 1993  
 Supersedes 91-78  
 TN No. 91-78

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3)(A), (B) and (C) of the Act	<p>c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard.</p> <p><input type="checkbox"/> Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><input checked="" type="checkbox"/> No. The agency does not apply a resource standard to these individuals.</p>
1902(1)(3)(A) and (C) of the Act	<p>d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard.</p> <p><input type="checkbox"/> Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><input checked="" type="checkbox"/> No. The agency does not apply a resource standard to these individuals.</p>

*eff. 1/1/93*

Revision: HCFA-PM-91-- (BPD)  
AUGUST 1991

ATTACHMENT 2.6-A  
Page 21a  
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State: New York

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is:  — Same as SSI resource standards.  — Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy).  <u>Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.</u>

91-78  
TN No. Supersedes **New** Approval Date MAR : 1 1992 Effective Date OCT 1 1991  
TN No. HCFA ID: 7985E

*official*

OFFICIAL

Revision:

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Page 22

State: New York

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Citation	Condition or Requirement
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7. Resource Standard - Medically Needy
- a. Resource standards are based on family size.
  - b. A single standard is employed in determining resource resource eligibility for all groups.
  - c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for--
    - Aged
    - Blind
    - Disabled

1902(a)(10)(C)(i)  
of the Act

Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to ATTACHMENT 2.6-A so indicates.

1902(a)(10)(E),  
1905(p)(1)(D), 1905(p)(2)(B)  
and 1860D-14(a)(3)(D)  
of the Act

8. Resource Standard - Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals

For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.

TN No: 10-15  
Supersedes TN No. 93-27

Approval Date SEP 15 2010, Effective Date April 1, 2010

State: New York

Citation	Condition or Requirement
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1902(a)(10)(E)(ii), 1905(s) and 1860D-14(a)(3)(D) of the Act

9. Resource Standard – Qualified Disabled and Working Individuals.

For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is two times the SSI resource limit.

1902(u) of the Act

10. For COBRA continuation beneficiaries, the resource standard is:

Twice the SSI resource standard for an individual.

More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

SEP 15 2010

TN No: 10-15

Approval Date

Effective Date April 1, 2010

Supersedes TN No. 91-78

**OFFICIAL**State: New York

Citation

Condition or Requirement

1902 (u) of the Act

11. Excess Resources\*

a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals

b. Categorically Needy Only

X This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

Any excess resources make the individual ineligible.

- *In accordance with Westmiller v. Sullivan, individuals are allowed to use incurred medical bills to offset excess resources and become eligible for Medicaid. See Supplement 8b to Attachment 2.6-A.*

**SEP 15 2010**TN No. 10-15

Approval Date: \_\_\_\_\_

Effective Date: April 1, 2010

Supersedes

TN No. 93-27

State NEW YORK

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Citation	Condition or Requirement
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_____	d. As specified in Supplement 4 to Attachment 2.6A, the agency disregards the value of resources in addition to items 5a-c.
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6.	Excess Resources — Categorically Needy and Medically Needy
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The method(s) checked below are used in handling resources in excess of those specified above:

a. Categorically Needy

Any excess resources make the individual ineligible.

This State has a section 1634 agreement with SSI. Conditional eligibility is provided for individuals who are receiving SSI while disposing of excess resources.

b. Medically Needy

The method(s) checked below is used in handling resources in excess of those specified above:

Excess non-income producing property (except the home) must be disposed of

Any excess resources render the individual ineligible

Other, described as follows:

Excess liquid assets are applied to cost of care

\* See Supplement 12, page 2 to Attachment 2.6A

NY 88-35  
Series  
NY NEW

Approval Date SEP 17 1990

Effective Date Oct. 1, 1982

official

State NEW YORK

ELIGIBILITY CONDITIONS AND REQUIREMENTS

**88 35**

Citation

Condition or Requirement

7. Treatment of Income and Resources — Medically  
Needy

\*X a. Individuals under 21

X The agency uses the same methodologies for  
treatment of income and resources as used in  
the AFDC State plan.

\*Except for the disregards as contained in NY 82-9 approved on 4/26/84  
effective 1/1/82 and as protected under the moratorium provision of the  
DRA. --

88-35  
Supersedes  
NEW

Approval Date SEP 17 1990

Effective Date Oct. 1, 1982

*official*

State: New York

Citation	Condition or Requirement
42 CFR 435.914	<p>11. Effective Date of Eligibility</p> <p>a. Groups Other Than Qualified Medicare Beneficiaries</p> <p>(1) For the prospective period.</p> <p>Coverage is available for the full month if the following individuals are eligible at any time during the month.</p> <p><input checked="" type="checkbox"/> Aged, blind, disabled. <input checked="" type="checkbox"/> AFDC-related.</p> <p>Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.</p> <p><input type="checkbox"/> Aged, blind, disabled. <input type="checkbox"/> AFDC-related.</p> <p>(2) For the retroactive period.</p> <p>Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:</p> <p><input type="checkbox"/> Aged, blind, disabled. <input type="checkbox"/> AFDC-related.</p> <p>Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied..</p> <p><input checked="" type="checkbox"/> Aged, blind, disabled. <input checked="" type="checkbox"/> AFDC-related.</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1920(b)(1) of the Act	<input checked="" type="checkbox"/> (3) For a presumptive eligibility period for pregnant women only.  Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.
1902(e)(8) and 1905(a) of the Act	<input checked="" type="checkbox"/> b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for--  <input checked="" type="checkbox"/> 12 months <input type="checkbox"/> 6 months <input type="checkbox"/> _____ months (no less than 6 months and no more than 12 months)

N.Y.

Citation	Condition or Requirement
1902(a)(18) and 1902(f) of the Act	<p>12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals</p> <p>The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.</p> <p>Disposal of resources at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9 to Attachment 2.6-A</u>.</p>
1917(c)	<p>13. Transfer of Assets - All eligibility groups</p> <p>The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.</p> <p>Disposal of assets at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9(a) to ATTACHMENT 2.6-A</u>, except in instances where the agency determines that the transfer rules would work an undue hardship.</p>
1917(d)	<p>14. Treatment of Trusts - All eligibility groups</p> <p>The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.</p> <p>— The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts;</p> <p>— The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of <u>Miller trusts</u>.</p> <p>The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in <u>Supplement 10 to ATTACHMENT 2.6-A</u>.</p>

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December 1997

ATTACHMENT 2.6-A  
Page 26a  
OMB No.: 0938-0673

State: New York

Citation Condition or Requirement

1924 of the Act

13. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community.

When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is:

- the maximum standard permitted by law;
- the minimum standard permitted by law; or
- \$74,820 a standard that is an amount between the minimum and the maximum.

**98-05**

TN No.  
Supersedes  
TN No.

**New**

Approval Date MAY 15 1998

Effective Date JAN 1 1998

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- **Supplement 5** – specifies the methods for determining resource eligibility used by states that have more restrictive methods than SSI
- **Supplement 5a** – methods for treatment of resources for individuals with incomes related to federal poverty levels
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### **3.1-A Amount, Duration and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy**

1. Inpatient hospital services
- 2a. Outpatient hospital services
- 2b. Rural health clinic services and other ambulatory services
- 2c. Federally Qualified Health Center (FQHC) services and other ambulatory services furnished by an FQHC
- 2d. Ambulatory services offered by health center with specific funding for pregnant or less than 18
3. Other laboratory and x-ray services
- 4a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older
- 4b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age
- 4c. Family planning services and supplies for individuals of child-bearing age
- 5a. Physicians' services
- 5b. Medical and surgical services furnished by a dentist

- 6a. Podiatrists' services
  - List of Available Organ Transplants
- 6b. Optometrists' services
- 6c. Chiropractors' services (EPSDT only)
- 6d. Other Practitioners' services
- 7. Home Health Services
  - 7a. Intermittent or part-time nursing services, provided by a home health agency or by a registered nurse when no home health agency exists in the area.
  - 7b. Home health services provided by a home health agency.
  - 7c. Medical supplies, equipment and appliances suitable for use in the home.
  - 7d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
- 8. Private duty nursing services
- 9. Clinic services
- 10. Dental services
- 11. Physical therapy and related services
  - 11a. Physical therapy
  - 11b. Occupational Therapy
  - 11c. Services provided for individuals with speech/hearing/language disorders (speech pathologist or audiologist)
- 12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
  - 12a. Prescribed drugs
  - 12b. Dentures
  - 12c. Prosthetic devices
  - 12d. Eyeglasses
- 13. Other diagnostic, screening, preventive and rehabilitative services, i.e. other than those provided elsewhere in the plan
  - 13a. Diagnostic services
  - 13b. Screening services
  - 13c. Preventive services
  - 13d. Rehabilitative services
- 14. Services for individuals age 65 or older in institutions for mental diseases
  - 14a. Inpatient hospital services
  - 14b. Skilled nursing facility services **(not provided)**
  - 14c. Intermediate Care Facility services (ICF) **(not provided)**
  - 15a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care
    - 15b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions
- 16. Inpatient psychiatric facility services for individuals under age 22
- 17. Nurse-midwife services
- 18. Hospice care
- 19. Case management services and special tuberculosis related services
  - 19a. Case management services as defined in, and to the group specified, in Supplement 1 to Attachment 3.1-A.
  - 19b. Special tuberculosis related services.

- 20. Extended services for pregnant women
- 21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period
- 22. Respiratory care services **(not provided)** (State statute does not recognize service, but it is available to EPSDT population through the clinic and home health benefit)
- 23. Pediatric or family nurse practitioners' services (New York State covers all nurse practitioner specialties recognized under State Law)
- 24. Any other medical care and any other type of remedial care recognized under State Law
- 24a. Transportation
- 24b. Services provided in Religious Nonmedical Health Care Institutions **(not provided)**
- 24c. Reserved
- 24d. Nursing facility services for patients under 21 years of age
- 24e. Emergency hospital services
- 24f. Personal Care Services
- 25. Home and Community Care for functionally disabled elderly individuals **(not provided)**
- 26. Personal care services for individual who is not an inpatient or resident of hospital, nursing facility, ICF for the mentally retarded or institution for mental disease
- 27. Primary Care Case Management
- Table of Covered Services for Pregnant Women
- 28. Program of All-Inclusive Care for Elderly (PACE) services

**Attachment 3.1A - Supplement – Prior Approval - Medical and Remedial Care Services Provided to the Categorically Needy (prior approval)** (must be in accordance with regulations of the Department of Health)

- 1. Inpatient care, services and supplies in general hospital
- 4a. Out of state placement at Specialized Care Facilities
- 5. Certain procedures which may be considered cosmetic or experimental (refer to MMIS Physician Provider Manual)
- 6. Must be in accordance with DOH regulations.
- 6a. FFS podiatry payments for Medicaid-eligible individuals under age 21 under the EPSDT program
  - Nursing facilities, Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) and Article 28 or 31 inpatient facilities and certified clinics which include foot care services
  - Limited laboratory tests in office setting, performed by podiatrist; radiological services within podiatry scope of practice; amputation and bunion surgery performed by podiatrist in hospital setting..... 2
- 4b. Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) - School Supportive Health Services and Pre-School Supportive Health Services..... 2(xii)(A)-2(xii)(P)
- 6d. Clinical psychologists (appropriate referral required)
- Pharmacists as Immunizers..... 2(xiv)(a)
- 6d. Nurse Practitioners' Services..... 2(xv)
- 6b. Orthoptic training..... 2(a)
- 6c. Chiropractor services, limited to EPSDT recipients..... 2(a)
- 6d. Clinical psychologists..... 2(a)
- 7a. Home care services provided by CHHA, including nursing, home health aide, PT/OT/ST, DME specialty items..... 2(a)
- 7b. Assisted Living Program..... 2(a)(i)
- 7c. Certain specialty items, including items identified in the MMIS DME provider manual, most repairs to DME, PERS, Personal Care Aide services, home health services. .... 2(a)(ii)
- 7d. Physical therapist, occupational therapist, speech pathologist definitions..... 2(a)(ii)

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9.	Clinic services - Article 28.....	2(a)(iii)
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	1. Outpatient drugs of manufacturer compliant with rebate agreement	
	2. Supplemental rebate program 0 includes National Medicaid Pooling Initiative (NMPI)	
	3. Changes to NMPI must be submitted to CMS.	
	4. Rebate required for new drug, unless drug is subject to allowable exclusion categories.	
	5. Rebate information not disclosed by state for purposes other than rebate invoicing and verification.	
	6. Part D drugs not covered for Medicare A/B-eligible individuals	
	7. Federally excluded drugs are covered.....	2b-2c
12b.	Prior approval required for all dentures.....	2c
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	Prior approval required for artificial eyes.....	2c
	Prior approval required for orthotics including hearing.....	2c
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13a.	Diagnostic Services, per 13d, Rehabilitative Services-Early Intervention....	2c
13b.	Screening Services, per 13d, Rehabilitative Services-Early Intervention.....	2c
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	o Off-site services for developmentally disabled persons as specified.....	2d
	o "Early Intervention" services for children who have or are suspected of having developmental delay or disability, limited to EPSDT, provided by or on behalf of a county or the City of New York, provided by or on behalf of a county or the City of NY pursuant to an Individualized Family Services Plan (IFSP):	
	1. Screening	
	2. Evaluation	
	3. Audiology	
	4. Nursing	
	5. Nutrition Services	
	6. OT	
	7. PT	
	8. Psychological Services	
	9. Social Work services	
	10. Anticipatory Guidance (special instruction and Allied Health Professional assistance)	
	11. Speech pathology services	
	12. Assistive technology services	
	13. Vision services	
	14. Collateral contacts for all of the above services.....	2d
	o Rehabilitative services for residents of community-based residential programs licensed by OMH (1. community residences, 2. family-based treatment, 3. teaching family homes).....	3a-3b

	○ Assertive Community Treatment.....	3b-1
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	○ includes personal mileage reimbursement.....	3(d)
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**General**

- a) Prior approval required for medical care and services to be provided outside New York State
- b) When a request for prior approval has been modified or denied, recipients are to be notified that they may request a fair hearing..... 4

**Additional Limitations-Utilization Threshold**, based on medical necessity, applies to the noted services 2a, 2b, 2c, 2d (2a-Outpatient hospital services, 2b-Rural health clinic services and other ambulatory services, 2c-Federally Qualified Health Center (FQHC) services and other ambulatory services furnished by an FQHC, 2d-Ambulatory services offered by health center with specific funding for pregnant or less than 18)...Utilization Threshold, based on medical necessity, applies to services 3, 5( 3-Other laboratory and x-ray services, 5-Physicians' Services..... 5

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● **Supplement 1 – Case Management Services**

- Target Group A - Male/female adolescent under 21 years of age, who is categorically needy or medically needed, deemed to be at risk of pregnancy or parenthood and meets defined criteria - not statewide, noncomparable Pages 1-A1 to 1-A12
- Target Group B - Persons enrolled in Medical Assistance who have diagnosis of MR/DD, in need ongoing comprehensive service coordination, do not reside in ICF, etc. - statewide, noncomparable Pages 1-B1 to 1-B9

- Target Group C - Categorically or medically needy individuals who are HIV-infected, HIV-antibody positive infants up to age 3 years prior to confirmation of seroconversion, all high risk individuals for period of up to 6 months - statewide, noncomparable- Pages 1-C1 to 1-C13
- Target Group D - Medical Assistance eligibles who are served by OMH Intensive Case Management Program, and who are seriously and persistently mentally ill (SPMI), requiring intensive personal intervention and are difficult to treat - statewide, noncomparable  
Pages 1-D1 to 1-D10
- Target Group D1 - description similar to above, except services are comparable  
Pages 1-D11 to 1-D22
- Target Group D2 - Medical Assistance eligibles who are served by OMH's Blended and Flexible Case Management Program who are SPMI, requiring intensive personal intervention and are difficult to treat -statewide, comparable  
Pages 1-D23 to 1-D34
- Target Group E - Medically or categorically needy individual who is either female of child bearing age and pregnant or parenting, and infants less than one year old - not statewide, noncomparable  
Pages 1 to 1-E6
- Target Group F - Categorically or medically needy who meet certain criteria (residing in areas of NYS designated as underserved and economically distressed through Neighborhood Based Alliance initiative - not statewide, noncomparable  
Pages 1-F1 to 1-F8
- Target Group G - Categorically or medically needy eligibles who are infants/toddlers birth to age 2 who have or are suspected to have a developmental delay or a diagnosed physical or mental condition that has potential to result in developmental delay; who have been referred to Early Intervention and are known to NYS DOH; who are in need of ongoing and comprehensive case management -statewide, noncomparable  
Pages 1-G1 to 1-G9
- Target Group H - Medical Assistance eligibles who are served by OMH's Supportive Case management program, who are seriously mentally requiring intensive personal intervention and are difficult to treat - statewide, noncomparable  
Pages 1-H1 to 1-H11
- Target Group I - Children 3-21 years who are federally eligible Medical Assistance EPSDT recipients, for whom protection is provided under Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973 - statewide, noncomparable  
Pages 1-I11 to 1-I8
- Targeted Case Management, Target Group M - First-time mothers and their newborns Not statewide (NYC and Monroe County), noncomparable  
Pages 1-M1 to 1-M8
- **Supplement 3 – PACE Services - Eligibility, Rates and payments, Enrollment/Disenrollment**  
Pages 1-7

### **3.1-B Amount, Duration and Scope of Services Provided to Medically Needy Group(s)**

1. Inpatient hospital services
- 2a. Outpatient hospital services
- 2b. Rural health clinic services and other ambulatory services
- 2c. Federally Qualified Health Center (FQHC) services and other ambulatory services furnished by an FQHC
- 2d. Ambulatory services offered by health center with specific funding for pregnant or less than 18
3. Other laboratory and x-ray services
- 4a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older
- 4b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age
- 4c. Family planning services and supplies for individuals of child-bearing age

- 5a. Physicians' services
- 5b. Medical and surgical services furnished by a dentist
  - List of Available Organ Transplants
- 6a. Podiatrists' services
- 6b. Optometrists' services
- 6c. Chiropractors' services (EPSDT only)
- 6d. Other Practitioners' services
- 7. Home Health Services
  - 7a. Intermittent or part-time nursing services, provided by a home health agency or by a registered nurse when no home health agency exists in the area.
  - 7b. Home health services provided by a home health agency.
  - 7c. Medical supplies, equipment and appliances suitable for use in the home.
  - 7d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
- 8. Private duty nursing services
- 9. Clinic services
- 10. Dental services
- 11. Physical therapy and related services
  - 11a. Physical therapy
  - 11b. Occupational Therapy
  - 11c. Services provided for individuals with speech/hearing/language disorders (speech pathologist or audiologist)
- 12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
  - 12a. Prescribed drugs
  - 12b. Dentures
  - 12c. Prosthetic devices
  - 12d. Eyeglasses
- 13. Other diagnostic, screening, preventive and rehabilitative services, i.e. other than those provided elsewhere in the plan
  - 13a. Diagnostic services
  - 13b. Screening services
  - 13c. Preventive services
  - 13d. Rehabilitative services
- 14. Services for individuals age 65 or older in institutions for mental diseases
  - 14a. Inpatient hospital services
  - 14b. Skilled nursing facility services (**boxes not checked-not provided**)
  - 14c. Intermediate Care Facility services (ICF) (**boxes not checked-not provided**)
  - 15a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care
    - 15b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions
- 16. Inpatient psychiatric facility services for individuals under age 22
- 17. Nurse-midwife services
- 18. Hospice care
- 19. Case management services and special tuberculosis related services

- 19a. Case management services as defined in, and to the group specified, in Supplement 1 to Attachment 3.1-A.
- 19b. Special tuberculosis related services.
- 20. Extended services for pregnant women
- 20a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60<sup>th</sup> day fails.
- 20b. Services for any other medical conditions that may complicate pregnancy.
- 21. Certified pediatric or family nurse practitioners' services
- 22. Respiratory care services
- 23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- 23a. Transportation
- 23b. Services provided in religious nonmedical health care institutions - **NOT PROVIDED**
- 23c. Reserved
- 23d. Nursing facility services for patients under 21 years of age
- 23e. Emergency hospital services
- 23f. Personal care services in patient's home
- 24. Home and community care for functionally disabled elderly individuals - **NOT PROVIDED**
- 25. Personal Care Services for an individual who is not inpatient or resident of hospital, nursing facility, ICF for mentally retarded or institution for mental disease, with specifics.
- 26. Primary Care Case Management
- 27. Program of All-Inclusive Care for the Elderly (PACE) to the medically needy

- **Attachment 3.1B - Supplement – Prior Approval - Medical and Remedial Care Services Provided to the Medically Needy (prior approval)** (must be in accordance with regulations of the Department of Health)

- 1. Inpatient care, services and supplies in general hospital
- 4a. Out of state placement at Specialized Care Facilities
- 5. Certain procedures which may be considered cosmetic or experimental (refer to MMIS Physician Provider Manual)
- 6. Must be in accordance with DOH regulations.
- 6a. FFS podiatry payments for Medicaid-eligible individuals under age 21 under the EPSDT program  
Nursing facilities, Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) and Article 28 or 31 inpatient facilities and certified clinics which include foot care services  
Limited laboratory tests in office setting, performed by podiatrist; radiological services within podiatry scope of practice; amputation and bunion surgery performed by podiatrist in hospital setting. .... 2
- 4b. Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) - School Supportive Health Services and Pre-School Supportive Health Services..... 2(xii)(A)-2(xii)(P)
- 6d. Clinical psychologists (appropriate referral required)
- Pharmacists as Immunizers..... 2(xiv)(a)
- 6d. Nurse Practitioners' Services..... 2(xv)
- 6b. Orthoptic training..... 2(a)
- 6c. Chiropractor services, limited to EPSDT recipients..... 2(a)
- 6d. Clinical psychologists..... 2(a)
- 7a. Home care services provided by CHHA, including nursing, home health aide, PT/OT/ST, DME specialty items..... 2(a)

7b.	Assisted Living Program.....	2(a)(i)
7c.	Certain specialty items, including items identified in the MMIS DME provider manual, most repairs to DME, PERS, Personal Care Aide services, home health services.....	2(a)(ii)
7d.	Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.....	2(a)(ii)
8.	Private duty nursing.....	2(a)(ii)
9.	Clinic services - Article 28.....	2(a)(iii)
10.	Dental care.....	2(a)(iii)
12a.	Some prescription drugs require prior authorization or dispensing validation. State established preferred drug program with PA for drugs not on preferred list. MA reimbursement available, limited to the following: .....	2b
	1. Outpatient drugs of manufacturer compliant with rebate agreement	
	2. Supplemental rebate program 0 includes National Medicaid Pooling Initiative (NMPI)	
	3. Changes to NMPI must be submitted to CMS.	
	4. Rebate required for new drug, unless drug is subject to allowable exclusion categories.	
	5. Rebate information not disclosed by state for purposes other than rebate invoicing and verification.....	2b
	6. Part D drugs not covered for Medicare A/B-eligible individuals	
	7. Federally excluded drugs are covered.....	2c
12b.	Prior approval required for all dentures.....	2c
12c.	Prior approval required for prosthetic and orthotic devices over a dollar amount established by DOH.....	2c
	Prior approval required for artificial eyes.....	2c
	Prior approval required for orthotics including hearing aids.....	2c
12d.	Prior approval required for certain special lenses and unlisted eye services.....	2c
13a.	Diagnostic Services, per 13d, Rehabilitative Services-Early Intervention.....	2c
13b.	Screening Services, per 13d, Rehabilitative Services-Early Intervention.....	2c
13c.	Preventive services, per 13d, Rehabilitative Services-Early Intervention.....	2c
13d.	Rehabilitative Services (13d)	
	1. Directly Observed Therapy.....	2d
	o Off-site services for developmentally disabled persons as specified.....	2d
	o "Early Intervention" services for children who have or are suspected of having developmental delay or disability, limited to EPSDT, provided by or on behalf of a county or the City of New York, provided by or on behalf of a county or the City of NY pursuant to an Individualized Family Services Plan (IFSP):	
	1. Screening	
	2. Evaluation	
	3. Audiology	
	4. Nursing	
	5. Nutrition Services	
	6. OT	
	7. PT	
	8. Psychological Services	
	9. Social Work services	
	10. Anticipatory Guidance (special instruction and Allied Health Professional assistance)	
	11. Speech pathology services	
	12. Assistive technology services	

	13. Vision services	
	14. Collateral contacts for all of the above services.....	2d
	o Rehabilitative services for residents of community-based residential programs licensed by OMH (1. community residences, 2. family-based treatment, 3. teaching family Homes).....	3a-3b
	o Assertive Community Treatment.....	3b-1
	o Personalized Recovery Oriented Services (PROS).....	3b-2 - 3b-3
18.	Rehabilitative Services, continued - "Off-site" .....	3(c)
	Limitations on Hospice Services (notations regarding palliative care, waiving Medicaid reimbursement, provider qualifications [RN, home health aide, physical therapy, occupational therapy, speech pathologist, personal care aide, housekeeper/homemaker, pastoral care coordinator, social workers, nutritionist, audiologist, respiratory therapist], etc.).....	3(c)-3(c)(iii)
19.	Limitations on Tuberculosis related services-DOT - only for clients being treated for TB..	3(c)(iii)
22.	Limitations on Respiratory Care - may be rendered to EPSDT population by medical necessity, furnished through clinic and home benefits.....	3(c)(iii)
23a.	Non-emergent transportation	
	o managed by each county's LDSS	
	o includes personal mileage reimbursement.....	3(d)
23d.	Skilled nursing facilities, except when admitted directly, and requires that facility be a Medicare provider.....	3(d)
25.	Personal Care Services.....	3(d)-(d)(A)
	Consumer Directed Personal Assistance Program (CDPAP).....	3(d)(i)
26.	Primary Care Case Management Program.....	3e

**General**

- a) Prior approval required for medical care and services to be provided outside New York State
- b) When a request for prior approval has been modified or denied, recipients are to be notified that they may request a fair hearing..... 4

**Additional Limitations-Utilization Threshold**, based on medical necessity, applies to the noted services 2a, 2b, 2c, 2d (2a-Outpatient hospital services, 2b-Rural health clinic services and other ambulatory services, 2c-Federally Qualified Health Center (FQHC) services and other ambulatory services furnished by an FQHC, 2d-Ambulatory services offered by health center with specific funding for pregnant or less than 18)...Utilization Threshold, based on medical necessity, applies to services 3, 5( 3-Other laboratory and x-ray services, 5-Physicians' Services..... 5

Utilization threshold decremented when patient seen by physician including for those times when seen by physician and electronic prescription/fiscal order is transmitted..... 5(a)

Utilization Threshold, based on medical necessity, applies to services 9, 11a-11c, 12a (9-Clinic Services, 11a-11c-Physical, Occupational and Speech therapy services, 12a-Prescribed drugs)..... 6-7

**3.1-C Standards and Methods of Assuring High Quality Care**

- a. provided in accordance with individual's medical needs based on prescription or recommendation of attending physician, dentist, other licensed practitioner eligible to participate in the program.
- b. all professional persons must be properly licensed under state law.

- c. institutions (e.g. hospitals, nursing homes), health related facilities (e.g. ICFs), medical facilities (clinics, laboratories), health agencies (community visiting nurse associations) must be licensed.
- d. procedures considered specialty must be performed by qualified specialists.
- e. home nursing services must conform to DOH standards.
- f. recommendation of appropriate specialist required when necessary (e.g. the more unusual prosthetic devices, rehabilitation therapy, orthodontia, etc.).
- g. each local welfare district must establish an adequate system of patient records demonstrating diagnoses and services provided.

C. Benchmark benefit package and benchmark equivalent benefit package, State elects to provide Alternative Benefit Plan A - Medication Therapy Management (MTM) Program

- 1. populations and geographic area covered
- 2. description of benefits
- 3. service delivery system
- 4. employer sponsored insurance - box not marked
- 5. assurances
- 6. economy and efficiency of plans
- 7. compliance with the law
- 8. implementation date

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**3.1-D Provisions for Providing Medical Assistance Transportation**

- A. Prior authorization
  - 1. Prior authorization required, specifics
  - 2. Criteria used, specifics
- B. Payment
  - 1. Criteria, specifics

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**3.1-E Standards for the Coverage of Organ Transplant Services**

- Services must be performed in hospitals approved by Commissioner of Health, and must be member of Organ Procurement and Transplantation Network.
- Hospital must participate in patient registry program
- Hospital must ensure written policies are developed.
- Chapter 589 of Laws of 1990 amended Public Health Law, specifics listed
- Hospital must maintain record of all patients referred, additional criteria listed

**3.1-F Enrollment into Managed Care Entities, and Chronic Illness Demonstration Project**

- A. Section 1932(a)(1)(A) of SSA
- B. General description of Chronic Illness Demonstration Project - Program and public process
- C. State assurances and compliance with Statute and regulations
- D. Eligible groups
- E. Identification of Mandatory Exempt Groups
- F. Other eligible groups - voluntary enrollment
- G. All other eligible groups
- H. Enrollment process
- I. State assurances on enrollment process
- J. Disenrollment
- K. Information requirements for beneficiaries
- L. List all services excluded for each model (MCO & PCCM)

M. Selective contracting under 1932 state plan option

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**3.2-A Medicare –Part A and B - Dual eligibles (Coordination of Title XIX with Part A and Part B of Title XVIII)**

A. Part B buy-in agreements with Secretary of HHS - specifics

B. Part A group premium payment arrangement

C. Payment of Part A and Part B deductible and coinsurance costs

Coordination of Title XIX with Part B of Title XVIII

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**4.11-A Standards for Institutions and Suppliers of Services**

**HEALTH**

**Citation: 10NYCRR Health, Volume A**

**Chapter II, Administrative Rules and Regulations**

Subchapter D - Laboratories - Part 58

**Citation: 10NYCRR Health, Volume A-1**

Subchapter J - Controlled Substances - Part 80

Subchapter K - Hospitals and related facilities - Part 81-83, 85

Subchapter L - X-ray technology and Chiropractic use of X-ray - Part 89

Subchapter M - Physician's assistance, prohibited discrimination in hospital staff appointments and privileges, Part 94

Subchapter N - Practice of Nursing Home administration and Home Nursing and Health services and agencies - Part 96

Subchapter P - Health Maintenance Organization - Part 98

**Citation: 10NYCRR Health, Volume C**

**Chapter V, Medical Facilities**

Subchapter A - Medical Facilities - Minimum standards - Article 1 through Article 7, Part 400-401, 405, 410-416, 420-421, 425-427, 430-431

Subchapter B - Hospital Establishment - Part 600, 610, 620, 630, 640, 650, 660, 670

Subchapter C - State Hospital Code - Article 1 through 8, Part 700, 702-703, 705-716, 720, 730-734, 740-742, 750-755, 760-767, 770-771, 780-782

**Chapter VI Emergency Services - Part 800**

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**MENTAL HYGIENE**

**Citation: 14NYCRR Mental Hygiene, Volume A**

**Chapter 1, General, Part 4, 8, 9**

**Chapter II, All Facilities**

Subchapter A - Admission and Transfer of Patients - Part 15-18

Subchapter B - Institutional Care and Treatment - Part 21-22, 24-25, 27

Subchapter C - Termination of Inpatient Care - part 36-37

Subchapter D - Safety - Part 45

Subchapter E - Facility Planning and Review - Part 51-53

**Chapter III, Department Facilities - Part 55-56**

**Chapter IV, Regulation and Safety Control**

Subchapter A - General Provisions - Part 70-73

Subchapter C - Construction of Facilities - Part 77-78

Subchapter D - Operation of Facilities - Part 82-85

**Chapter VII, Mental Hygiene Facilities Improvement Fund - Part 150**

**Chapter VIII, Drugs** - Part 201-202  
**Chapter X Alcoholism** - Part 303-306, 330, 368-369, 395

**Citation: 14NYCRR, Mental Hygiene, Volume B**  
**Chapter XIII Office of Mental Health** - Part 540-542, 561, 575, 583-586  
**Chapter XIV Office of Mental Retardation and Developmental Disabilities** - Part 676, 679-681, 688, 690  
**Chapter XX Commission on Quality of Care** - Part 700  
**Chapter XXV Division of Substances Abuse Services** - Part 1000, 1010, 1020, 1030, 1040, 1060  
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#### **SOCIAL SERVICES**

**Citation: 18NYCRR Social Services, Volume B**  
**Chapter II Regulations of the Department of Social Services**  
**Subchapter C - Social Services** - Article 2-3, 5-6, Part 428, 441-444, 447-449, 451, 476-477, 481-484  
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#### **4.14-B Utilization Control in Intermediate Care Facilities**

1. Review in ICFs is provided through facility-based reviews.
2. Review in ICFs for mentally retarded is through NYS OMRDD, Division of Quality Assurance staff, as well as independent contracted organizations.

#### **4.16-A Summary of Cooperative Arrangements with State Health and State Vocational Rehabilitation Agencies and with Title V Grantees**

##### Cooperative Agreement

- I. Federal Relations
- II. Medical Assistance eligibility
- III. Medical standards and program oversight
- IV. Program management and administration
- V. Rates and fees
- VI. Reports, forms and procedures
- VII. Grievance proceedings and appeals - recipients
- VIII. Monitoring and enforcement of agreement
- IX. Administrative Proceedings - providers
- X. Civil proceedings
- XI. Criminal prosecution
- XII. Federal advances
- XIII. Staffing
- XIV. Miscellaneous
- XV. Terms of Agreement

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Summary of agreement, outlines provision of coverage under Medical Assurances, NYSDSS duties, NYSOMH duties, NYSDAA duties, DMA and CCH duties, DSS and OVR responsibilities, DSS and SED, DSS/SED/OMRDD responsibilities  
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#### **4.17-A Liens and Adjustments or Recoveries**

1. Process for determining institutionalized individual - see Supplement to 4.17-A
2. Criteria for establishing institutionalized individual's child provided care
3. Definitions of terms
4. Undue hardship

- 5. Procedures for waiving estate recoveries - see Supplement to 4.17-A
- 6. Cost-effectiveness
- 7. Collection procedures

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**Supplement to Attachment 4.17A**

- 1. Determination of when it's presumed individual will not return home
- 5. Notification

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**4.18-A The Method Used to Collect Cost-Sharing Charges for Categorically Needy Individuals (Co-Payments)**

- Supplement 1 Co-Pay Exclusions

**4.18-C Charges Imposed on the Medically Needy for Services—(Co-Pays)**

- Supplement 1 – Copay Exclusions

**4.18-D Premiums Imposed on Low Income Pregnant Women and Infants**

**4.18-E Optional Sliding Scale Premiums Imposed on Qualified Disabled and Working Individuals**

**Part 4.19-A of the State Plan**

**4.19-A Part I - Establishing Payment Rates—Inpatient Hospital Care (10 NYCRR 86-1)**

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2. Has there been a high utilization of medical services by the A/R? Request all medical bills, statement of insurance benefit payments, determine the total amount paid by all parties.
3. Can the past utilization of medical expenses be expected to continue or increase?
4. Does a situation exist which warrants maintaining the policy even though there is no history of high medical utilization?
5. For policies in force, what are the maximum benefit levels?
6. Review the number of dependents in a family.
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### Medicaid Services

Title XIX of the Social Security Act requires that in order to receive Federal matching funds, certain basic services must be offered to the categoryally needy population in any State program:

- inpatient hospital services;
- outpatient hospital services;
- physician services;
- medical and surgical dental services;
- nursing facility (NF) services for individuals aged 21 or older;
- home health care for persons eligible for nursing facility services;
- family planning services and supplies;
- rural health clinic services and any other ambulatory services offered by a rural health clinic that are otherwise covered under the State plan;
- laboratory and x-ray services;
- pediatric and family nurse practitioner services;
- federally-qualified health center services and any other ambulatory services offered by a federally-qualified health center that are otherwise covered under the State plan;
- nurse-midwife services (to the extent authorized under State law); and
- early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals under age 21.

If a State chooses to include the medically needy population, the State plan must provide, as a minimum, the following services:

- prenatal care and delivery services for pregnant women;
- ambulatory services to individuals under age 18 and individuals entitled to institutional services;
- home health services to individuals entitled to nursing facility services; and
- if the State plan includes services either in institutions for mental diseases or in intermediate care facilities for the mentally retarded (ICF/MRs), it must offer either of the following to each of the medically needy groups: the services contained in 42 CFR sections 440.10 through 440.50 and 440.165 (to the extent that nurse-midwives are authorized to practice under State law or regulations); or the services contained in any seven of the sections in 42 CFR 440.10 through 440.165.

States may also receive Federal funding if they elect to provide other optional services. The most commonly covered optional services under the Medicaid program include:

- OPTIONAL*
- clinic services;
  - nursing facility services for the under age 21;
  - intermediate care facility/mentally retarded services;
  - optometrist services and eyeglasses;

- prescribed drugs;
- ✕• TB-related services for TB infected persons;
- prosthetic devices; and
- dental services.

HCBS

States may provide home and community-based care waiver services to certain individuals who are eligible for Medicaid. The services to be provided to these persons may include case management, personal care services, respite care services, adult day health services, homemaker/home health aide, habilitation, and other services requested by the State and approved by HCFA.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 gives States the option to provide medical services to certain women who have been found to have breast or cervical cancer or precancerous conditions. For further information, see the Medicaid BCCPT information website. States may also receive enhanced funding for this new option.

### **Amount and Duration of Medicaid Services**

Within broad Federal guidelines, States determine the amount and duration of services offered under their Medicaid programs. The amount, duration, and scope of each service must be sufficient to reasonably achieve its purpose. States may place appropriate limits on a Medicaid service based on such criteria as medical necessity or utilization control. For example, States may place a reasonable limit on the number of covered physician visits or may require prior authorization to be obtained prior to service delivery.

{ Health care services identified under the EPSDT program as being "medically necessary" for eligible children must be provided by Medicaid, even if those services are not included as part of the covered services in that State's plan.

With certain exceptions, a State's Medicaid plan must allow recipients freedom of choice among health care providers participating in Medicaid. States may provide and pay for Medicaid services through various prepayment arrangements, such as a health maintenance organization (HMO). In general, States are required to provide comparable services to all categorically needy eligible persons.

There is an important exception related to home and community-based services "waivers" under which States offer an alternative health care package for persons who would otherwise be institutionalized under Medicaid. States are not limited in the scope of services they can provide under such waivers so long as they are cost effective (except that, other than as a part of respite care, they may not provide room and board for such recipients).

### **Payment for Medicaid Services**

Medicaid operates as a vendor payment program, with payments made directly to the providers. Providers participating in Medicaid must accept the Medicaid reimbursement level as payment in full. Each State has relatively broad discretion in determining (within federally-imposed upper limits and specific restrictions) the reimbursement methodology and resulting rate for services, with three exceptions: (1) for institutional services, payment may not exceed amounts that would be paid under Medicare payment rates; (2) for disproportionate share hospitals (DSHs), different limits apply; and (3) for

hospice care

*Copayments  
&  
exceptions*

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid recipients for certain services. Emergency services and family planning services must be exempt from such copayments. Certain Medicaid recipients must be excluded from this cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy HMO enrollees.

The amount of total Federal outlays for Medicaid has no set limit (cap); rather, the Federal government must match whatever the individual State decides to provide, within the law, for its eligible recipients. However, reimbursement rates must be sufficient to enlist enough providers so that Medicaid care and services are available under the plan at least to the extent that such care and services are available to the general population in that geographic area.

*DSH*

States must augment payment to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or other low-income persons under what is known as the disproportionate share hospital (DSH) program. Legislation passed in 1991 has curtailed some States DSH payments.

*FMAP*

The portion of the Medicaid program which is paid by the Federal government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each State by a formula that compares the State's average per capita income level with the national average. By law, the FMAP cannot be lower than 50 percent nor greater than 83 percent. The wealthier States have a smaller share of their costs reimbursed. The Federal government also shares in the State's expenditures for administration of the Medicaid program. Most administrative costs are matched at 50 percent for all States. However, higher matching rates (75, 90 and 100 percent) are authorized by law for certain functions and activities. State FMAPs are listed in the chapter with financial statistics.

## Medicaid Trends

Initially, Medicaid was a medical care extension of federally funded income maintenance programs for the poor, with an emphasis on the aged, the disabled and dependent children and their mothers. Over time, however, Medicaid has been diverging from a firm tie to eligibility for cash programs. Recent legislation ensures Medicaid coverage to an expanded number of low-income pregnant women, poor children, and some Medicare beneficiaries who are not eligible for any cash assistance program, and would not have been eligible for Medicaid under earlier Medicaid rules. Legislative changes focus on enhanced outreach toward specific groups of pregnant women and children, increased access to care, and improved quality of care. Legislation also continued specific benefits beyond the normal run of Medicaid eligibility and placed some restrictions on States' ability to limit some services.

In addition to the increase in numbers of beneficiaries from new legislation, the most pronounced Medicaid service-related trends in recent years have been the continued sharp increase in expenditures for intensive acute care and for home health and nursing facility services for the aged and disabled.

*mgd Care*

The most significant trend in service delivery is the rapid growth in managed

care enrollment within Medicaid. In 1995 almost a quarter of all Medicaid recipients were enrolled in managed care plans. One vehicle for the expansion of managed care, and of new eligibility groups, is the 1915(b) waiver process which allows States increased flexibility to research health care delivery alternatives while controlling program costs. Another vehicle is the section 1115 (b) waiver authority which permits States to implement managed care delivery systems within prescribed parameters.



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**NEW YORK STATE  
DEPARTMENT OF HEALTH**

**COMPREHENSIVE MEDICAID CASE MANAGEMENT (CMCM)**

CMCM Program	Description	ADMs, LCMs, INFs	DOH Contact
OMRDD Medicaid Service Coordination (MSC)	Administered by the Office of Mental Retardation and Developmental Disabilities (OMRDD) for individuals who are developmentally disabled and choose to receive Medicaid Service Coordination (MSC) services.	90-LCM-36 GIS 00 MA006 (MSC)	Aileen Gertzberg (518) 473-5873
OMH Case Management	Administered by the Office of Mental Health (OMH) through the Supportive Case Management (SCM), Intensive Case Management (ICM), and Blended and Flexible Case Management programs for individuals who are seriously & chronically mentally ill.	90-LCM-16 91-LCM-36 97-LCM-17 89ADM-29 MA Update Feb 1998 Dec. 1997	Larry Moss (518) 473-5873
Early Intervention (EI) Service Coordination	Administered by the Department of Health Early Intervention Program to provide early intervention services for infants and toddlers (0 to 2) who are developmentally disabled or at risk of developmental disabilities.	94 LCM-2 Early Intervention Memorandum 94-4 in Jan. 2000	Peggy Smith (518) 473-0149
AIDS Case Management	Administered by the Department of Health through the AIDS Institute for individuals with HIV/AIDS.	90-LCM-131	Jay Freedman (518) 486-1323
School Supportive Health Services (SSHP) Case Management	Initiative to reimburse school districts for special education services provided to Medicaid eligible children with handicapping conditions.		Mike Albino (518) 473-9059
Teen Age Services (TASA) Case management	A local initiative CMCM program that the LDSS may administer to fulfill their TASA mandate provide case management services for eligible pregnant, parenting and at-risk adolescents.	89-ADM-29 92-LCM-56	Sue Brownell (518) 474-9068
CONNECT/ Onondaga County Case Management	A local initiative CMCM program that the LDSS administers for women of child-bearing age who are pregnant or parenting infants under one year of age. CONNECT is targeted in certain zip codes of Kings, Bronx and New York Counties. Onondaga Co. initiative is targeted to all of Onondaga County.		Gail Gordon (CONNECT) (212) 268-6855 Sue Brownell (518) 474-9068
Neighborhood Based Alliance (NBA) Case Management	A local initiative CMCM program that the LDSS administers for individuals residing in under-served and economically distressed areas designated under Chapter 65 of the Laws of 1990. Programs currently operate in Steuben and Oswego Counties.		Sue Brownell (518) 474-9068

1/8/02

GROUP

E

G

A

A

F

... PLAN UNDER TITLE III  
OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM

ETA-AT-30-38 (LPP) ...  
MAY 22, 1980

...  
...  
...

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
Medical Assistance Program

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State/Territory: \_\_\_\_\_

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Supersedes TN No. 87-47 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
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	* Supplement 3 - Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
	* Supplement 4 - Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

\*Forms Provided

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* Supplement 5 -	Section 1902(f) Methodologies for Treatment of Resources that Differ from those of the SSI Program
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* Supplement 11-	Cost-Effective Methods for COBRA Groups (States and Territories)
*2.6-A	<u>Eligibility Conditions and Requirements (Territories only)</u>
* Supplement 1 -	Income Eligibility Levels - Categorically Needy, Medically Needy, and Qualified Medicare Beneficiaries
* Supplement 2 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
* Supplement 3 -	Resource Levels for Optional Groups with Incomes Up to a Percentage of the Federal Poverty Level and Medically Needy
* Supplement 4 -	Consideration of Medicaid Qualifying Trusts--Undue Hardship
* Supplement 5 -	More Liberal Methods of Treating Income under Section 1902(r)(2) of the Act
* Supplement 6 -	More Liberal Methods of Treating Resources under Section 1902(r)(2) of the Act

\*Forms Provided.

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TN No. 91-54 JUL 27 1995  
Supersedes Approval Date \_\_\_\_\_ Effective Date JUL 1 - 1991  
TN No. 91-75  
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No.	Title of Attachment
*3.1-A	Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy <i>* Prior Approval &amp; Utilization Threshold</i>
	* Supplement 1 - Case Management Services
	<i>NIA</i> Supplement 2 - Alternative Health Care Plans for Families Covered Under Section 1925 of the Act
	* Supplement 3 - <i>PACE Services</i>
*3.1-B	Amount, Duration, and Scope of Services Provided Medically Needy Groups <i>* Prior Approval &amp; Utilization Threshold</i>
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*3.1-E	Standards for the Coverage of Organ Transplant Procedures <i>3.12</i>
4.11-A	Standards for Institutions <i>Continuation of Title XIX with Part A and Part B of Title XVIII</i>
4.14-A	Single Utilization Review Methods for Intermediate Care Facilities
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*4.18-E	Premiums Imposed on Qualified Disabled and Working Individuals
4.19-A	Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

\*Forms Provided

TN No. 91-1-13  
Supersedes 87-49 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
TN No. 87-49 HCFA ID: 7982E

<u>No.</u>	<u>Title of Attachment</u>
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4.19-C	Payments for Reserved Beds
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4.22-A	Requirements for Third Party Liability--Identifying Liable Resources
*4.22-B	Requirements for Third Party Liability--Payment of Claims
*4.22-C	Cost-Effective Methods for Employer-Based Group Health Plans
*4.32-A	Income and Eligibility Verification System Procedures: Requests to Other State Agencies
*4.33-A	Method for Issuance of Medicaid Eligibility Cards to Homeless Individuals
7.2-A	Methods of Administration - Civil Rights (Title VI)

\*Forms Provided

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TN No. <u>91-54</u>	Approval Date <u>JUL 27 1995</u>	Effective Date <u>JUL 1 - 1991</u>
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TN No. <u>91-75</u>		

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91-39

*Prior Approval*

ATTACHMENT 3.1-A  
Supplement

NEW YORK STATE - TITLE XIX STATE PLAN

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY.

NOTE: By prior approval, when indicated below, is meant that prior approval/authorization of the local professional director and/or the local social services commissioner is required for that service.

- Inpatient care, services and supplies in a general hospital shall, in the case of a person admitted to such a facility on a Friday or Saturday, be deemed to include only those inpatient days beginning with and following the Sunday after such date of admission, unless such care, services and supplies are furnished for an actual medical emergency or pre-operative care for surgery as provided in paragraph (d) of subdivision five of section 365a of the Social Services Law, or are furnished because of the necessity of emergency or urgent surgery for the alleviation of severe pain or the necessity for immediate diagnosis or treatment of conditions which threaten disability or death if not promptly diagnosed or treated; provided, however, inpatient days of a general hospital admission beginning on a Friday or a Saturday shall be included commencing with the day of admission in a general hospital which the commissioner or his designee has found to be rendering and which continues to render full service on a seven day a week basis which determination shall be made after taking into consideration such factors as the routine availability of operating room services, diagnostic services and consultants, laboratory services, radiological services, pharmacy services, staff patterns consistent with full services and such other factors as the commissioner or his designee deems necessary and appropriate.

Inpatient care, services and supplies in a general hospital shall not include care, services and supplies furnished to patients for certain uncomplicated procedures which may be performed on an outpatient basis in accordance with regulations of the commissioner of health, unless the person or body designated by such commissioner determines that the medical condition of the individual patient requires that the procedure be performed on an inpatient basis.

- Limits other than medical necessity are not applicable to EPSDT recipients in accord with 1203(r)5.
- We have received the State Plan and reviewed it and determined that we are in compliance with EPSDT requirements

TN 91-39 Approval Date FEB 18 1992  
Supersedes TN 85-30 Effective Date JUL 01 1991

4a. Prior approval is required for all out-of-state placements at Specialized Care Facilities for difficult to place individuals or High level Care facilities for the head injured.

Medicaid payments shall not be authorized for nursing facilities which are not certified or have not applied for certification to participate in Medicare.

Care days in nursing facilities is reimbursed for Medicaid patients requiring and receiving medically necessary lower level of care services. Medical Assistance is provided until such time as the appropriate level of care becomes available.

5. Prior approval is required for certain procedures which may be considered cosmetic or experimental. Physicians are informed of the specific prior approval requirements in the MMIS Physician Provider Manual.

6. Care and services will be provided only if they are in accordance with regulations of the Department of Health.

6a. Medicaid does not cover routine hygienic care of the feet in the absence of pathology.

Fee for service podiatry payments will only be made for services provided to Medicaid eligibles under twenty-one years of age under the EPSDT program and only by written referral from a physician, physician's assistant, nurse practitioner or certified nurse midwife.

Nursing facilities, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD's), and Article 28 or Article 31 inpatient facilities and certified clinics which include foot care services in the rate established for medical care for Medicaid recipients will continue to receive payments for these services through their rates. Additionally, Medicaid will continue to pay for medically necessary items and supplies (e.g., prescriptions drugs) for all recipients when ordered by a private practicing podiatrist.

In the office setting, a podiatrist may only provide a limited number of clinical laboratory tests. Podiatrists are informed of the specific clinical laboratory tests they may perform, in their office setting, in the MMIS Podiatrists Manual. A podiatrist may only provide radiological services which are within the scope of podiatric practice. Amputation and bunion surgery may be performed by a podiatrist in a hospital setting.

TN 93-52 Approval Date DEC 14 1993  
Supersedes TN 92-57 Effective Date JUL 1 - 1993

State/Territory: New York

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.  
Provided:  No limitations  With limitations\*
- 2.a. Outpatient hospital services.  
Provided:  No limitations  With limitations\*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.  
 Provided:  No limitations  With limitations\*  
 Not provided.
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).  
 Provided:  No limitations  With limitations\*
- d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.  
 Provided:  No limitations  With limitations\*
3. Other laboratory and x-ray services.  
Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN 91-75  
Supersedes 91-52 Approval Date MAR 1991 Effective Date OCT 1 1991  
TN No. 91-52

HCFA ID: 7986E

State/Territory: New York

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.  
Provided:  No limitations  With limitations\*
- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.\*
- 4.c. Family planning services and supplies for individuals of child-bearing age.  
Provided:  No limitations  With limitations\*
- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.  
Provided:  No limitations  With limitations\*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).  
Provided:  No limitations  With limitations\*
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' services.  
Provided:  No limitations  With limitations\*

\*4(b) limited to federal requirements under 1905(a) per section 1905(r) per PM 90-2.

\* Description provided on attachment.

TN No. 93-27  
Supersedes 91-75 Approval Date SEP 14 1993 Effective Date APR 1 1993  
TN No. 91-75

List of Available Organ Transplants - categorically needy

- heart
- kidney
- liver
- bone
- skin
- cornea
- heart/lung
- bone marrow

TN 91-39 Approval Date EEB 18 1992

Supersedes TN **New** Effective Date JUL 01 1991

State/Territory: New York

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Chiropractors' services. *(EPSDT only.)*

Provided:  No limitations  With limitations\*  
 Not provided.

d. Other practitioners' services.

Provided: Identified on attached sheet with description of  
limitations, if any.  
 Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health  
agency or by a registered nurse when no home health agency exists in the  
area.

Provided:  No limitations  With limitations\*

b. Home health aide services provided by a home health agency.

Provided:  No limitations  With limitations\*

c. Medical supplies, equipment, and appliances suitable for use in the  
home.

Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No. 91-11

Supersedes

TN No. 91-75

Approval Date

MAY 16 1995

Effective Date JAN 1 - 1994

HCFA ID: 7986E

State/Territory: New York

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Provided:  No limitations  With limitations\*  
 Not provided.

8. Private duty nursing services.

Provided:  No limitations  With limitations\*  
 Not provided.

\*Description provided on attachment.

TN No. 91-75 MAR 3 1992  
Supersedes New Approval Date \_\_\_\_\_ Effective Date OCT 1 1991  
TN No. New HCFA ID: 7986E

AMOUNT, DURATION AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

Provided:  No limitations

With limitations\*

Not provided.

10. Dental services.

Provided:  No limitations

With limitations\*

Not provided.

11. Physical therapy and related services.

a. Physical therapy.

Provided:  No limitations

With limitations\*

Not provided.

b. Occupational therapy.

Provided:  No limitations

With limitations\*

Not provided.

c. Services for individuals with speech, hearing, and language disorders  
(provided by or under the supervision of a speech pathologist or  
audiologist).

Provided:  No limitations

With limitations\*

Not provided.

\*Description provided on attachment.

TM No.

01-52

Supersedes

TM No.

85-30

Approval Date DEC 3 1991

Effective Date JUL 1 1991

HCFA ID: 0069P/0002P

AMOUNT, DURATION AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

Provided:  No limitations  With limitations\*  
 Not provided.

b. Dentures.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Prosthetic devices.

Provided:  No limitations  With limitations\*  
 Not provided.

d. Eyeglasses.

Provided:  No limitations  With limitations\*  
 Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

Provided:  No limitations  With limitations\*  
 Not provided.

\*Description provided on attachment.

93-49  
TN No. 93-49  
Supersedes  
TN No. 85-30

Approval Date MAR 08 1985

Effective Date SEP 1 - 1993

AMOUNT, DURATION AND SCOPE OF MEDICAL  
AND REHABILITATIVE CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

Provided:  No limitations  With limitations  
 Not provided.

c. Preventive services.

Provided:  No limitations  With limitations  
 Not provided.

d. Rehabilitative services.

Provided:  No limitations  With limitations  
 Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

Provided:  No limitations  With limitations  
 Not provided.

b. Skilled nursing facility services.

Provided:  No limitations  With limitations  
 Not provided.

c. Intermediate care facility services.

Provided:  No limitations  With limitations  
 Not provided.

\*Description provided on attachment.

TN 93-49 Approval Date MAR 08 1995

Supersedes TN 92-10 Effective Date SEP 1 - 1993

AMOUNT, DURATION AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Provided:  No limitations  With limitations\*  
 Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided:  No limitations  With limitations\*  
 Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Provided:  No limitations  With limitations\*  
 Not provided.

17. Nurse-midwife services.

Provided:  No limitations  With limitations\*  
 Not provided.

18. Hospice care (in accordance with section 1905(c) of the Act).

Provided:  No limitations  With limitations\*  
 Not provided.

\*Description provided on attachment.

TN No. 86-30  
Supersedes  
TN No. 85-30

Approval Date SEP 11 1986

Effective Date 01 OCT 1986

HCFA ID: 0069P/0002P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Provided:  With limitations

Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

Provided:  With limitations\*

Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

\*Description provided on attachment.

94-39  
TN No. 94-14 Supersedes Approval Date NOV 23 1994 Effective Date JAN 1 - 1994

Revision: HCFA-PM-91 (BPD)  
AUGUST 1991

OFFICIAL

Attachment 3.1-A  
Page 8a  
OMB No.: 0938-

State/Territory: NEW YORK

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a Presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

Provided:       No limitations       With limitations \*  
 Not provided

22. Respiratory care services (in accordance with section 1902 (e) (9) (A) Through (C) of the Act. \*

Provided:       No limitations       With limitations \*  
 Not provided

23. Pediatric or family nurse practitioners' services. [\*\*]

Provided:       No limitations       With limitations \*

\* State statute does not recognize service, but it is available to EPSDT population through the clinic and home health benefit.

[\*\* New York State covers all nurse practitioner specialties Recognized under State Law.]

\* Description provided on attachment.

TN#: #09-53

Approval Date: APR 08 2010

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Effective Date: NOV 15 2009



State: New York

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL  
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Provided  Not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

Provided:  State Approved (Not Physician) Service Plan Allowed

Services Outside the Home Also Allowed

Limitations Described on Attachment

Not Provided

27. Primary Care Case Management

Provided

Not Provided

TN NO. 00-43  
Supersedes  
TN

Approval Date

Effective Date OCT 01 2000

TN 00-43 Approval Date MAR 28 2001

Supersedes TN 94-49 Effective Date OCT 01 2000

# Covered Services For Pregnant Women

DESCRIPTION	PRESUMPTIVE ELIGIBILITY			ONGOING MEDICAID ELIGIBILITY		
	≤ 100 X	≤ 105 X	RA	≤ 100 X	≤ 105 X	PRENATAL CARE
UNB COVERAGE CODE	13	16	01	01	01	15
INCLUDED SERVICES	PHYSICIAN CARE MIDWIFE CARE OUTPATIENT CLINIC PHARMACY DENTAL LABORATORY EYE CARE TRANSPORTATION HOME HEALTH CARE PERSONAL CARE NURSING SERVICES PODIATRY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY DURABLE MED. EQUIP. ABORTION CLINICAL PSYCHOLOGY OUTPATIENT/MENTAL HEALTH OUTPATIENT/ALCOHOLISM HEALTH EDUCATION NUTRITIONAL COUNSELING FAMILY PLANNING	PHYSICIAN CARE MIDWIFE CARE OUTPATIENT CLINIC PHARMACY DENTAL LABORATORY TRANSPORTATION HOME HEALTH CARE PERSONAL CARE NURSING SERVICES CLINICAL PSYCHOLOGY OUTPATIENT/MENTAL HEALTH OUTPATIENT/ALCOHOLISM HEALTH EDUCATION NUTRITIONAL COUNSELING FAMILY PLANNING	PHYSICIAN CARE MIDWIFE CARE OUTPATIENT CLINIC PHARMACY DENTAL LABORATORY TRANSPORTATION HOME HEALTH CARE PERSONAL CARE NURSING SERVICES PODIATRY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY DURABLE MED. EQUIP. ABORTION CLINICAL PSYCHOLOGY OUTPATIENT/MENTAL HEALTH OUTPATIENT/ALCOHOLISM HEALTH EDUCATION NUTRITIONAL COUNSELING FAMILY PLANNING HOSPICE INPATIENT CARE ALTERNATE LEVEL CARE INSTITUTIONAL LTC	PHYSICIAN CARE MIDWIFE CARE OUTPATIENT CLINIC PHARMACY DENTAL LABORATORY TRANSPORTATION HOME HEALTH CARE PERSONAL CARE NURSING SERVICES PODIATRY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY DURABLE MED. EQUIP. ABORTION CLINICAL PSYCHOLOGY OUTPATIENT/MENTAL HEALTH OUTPATIENT/ALCOHOLISM HEALTH EDUCATION NUTRITIONAL COUNSELING FAMILY PLANNING HOSPICE INPATIENT CARE ALTERNATE LEVEL CARE INSTITUTIONAL LTC	PHYSICIAN CARE MIDWIFE CARE OUTPATIENT CLINIC PHARMACY DENTAL LABORATORY TRANSPORTATION HOME HEALTH CARE PERSONAL CARE NURSING SERVICES PODIATRY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY DURABLE MED. EQUIP. ABORTION CLINICAL PSYCHOLOGY OUTPATIENT/MENTAL HEALTH OUTPATIENT/ALCOHOLISM HEALTH EDUCATION NUTRITIONAL COUNSELING FAMILY PLANNING HOSPICE INPATIENT CARE ALTERNATE LEVEL CARE INSTITUTIONAL LTC	PHYSICIAN CARE MIDWIFE CARE OUTPATIENT CLINIC PHARMACY DENTAL LABORATORY TRANSPORTATION HOME HEALTH CARE PERSONAL CARE NURSING SERVICES CLINICAL PSYCHOLOGY OUTPATIENT/MENTAL HEALTH OUTPATIENT/ALCOHOLISM HEALTH EDUCATION NUTRITIONAL COUNSELING FAMILY PLANNING IMPATIENT CARE
EXCLUDED SERVICES	INPATIENT CARE ALTERNATE LEVEL CARE INSTITUTIONAL LTC LT HOME HEALTH CARE	INPATIENT CARE ALTERNATE LEVEL CARE INSTITUTIONAL LTC PODIATRY EYE CARE DURABLE MED. EQUIP. ABORTION PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY HOSPICE LT HOME HEALTH CARE	NONE	NONE	NONE	ALTERNATE LEVEL CARE INSTITUTIONAL LTC PODIATRY EYE CARE DURABLE MED. EQUIP. ABORTION PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY HOSPICE LT HOME HEALTH CARE

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

28. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

Revision: HCFA-PH-86-20 (BERC)  
SEPTEMBER 1986

86 30

ATTACHMENT 3.1-B  
Page 1  
OMB No. 0938-0193

State/Territory: New York

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

The following ambulatory services are provided.

\*Description provided on attachment.

TH No. 86-30  
Supersedes  
TH No. 82-9

Approval Date SEP 11 1990

Effective Date 01 OCT 1986

HCFA ID: 0140P/01021

R/O II - 10/91

State/Territory: New York

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDED

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided:  No limitations  With limitations\*

2.a. Outpatient hospital services.

Provided:  No limitations  With limitations\*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

Provided:  No limitations  With limitations\*

Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided:  No limitations  With limitations\*

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

Provided:  No limitations  With limitations\*

3. Other laboratory and X-ray services.

Provided:  No limitations  With limitations\*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided:  No limitations  With limitations\*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

Provided:  No limitations  With limitations\*

Not provided.

c. Family planning services and supplies for individuals of childbearing age.

Provided:  No limitations  With limitations\*

\*4(b) limited to federal requirements under 1905(a) per section 1905(r) per PM 90-2.

\*Description provided on attachment.

State/Territory: New York

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY  
GROUP(s): \_\_\_\_\_

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: \_\_\_ No limitations X With limitations\*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: \_\_\_ No limitations X With limitations:

\*Description provided on attachment.

TN No. 93-27 Approval Date SEP 14 1993 Effective Date APR 1 1993  
Supersedes 91-75  
TN No. \_\_\_\_\_

List of Available Organ Transplants - medically needy

- heart
- kidney
- liver
- bone
- skin
- cornea
- heart/lung
- bone marrow

TN 91-39 Approval Date FEB 18 1992  
Supersedes TN New Effective Date JUL 01 1991

State/Territory: New York

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S):**

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' Services  
 Provided:  No limitations  With limitations
  - b. Optometrists' Services  
 Provided:  No limitations  With limitations
  - c. Chiropractors' Services *(EPSDT only)*  
 Provided:  No limitations  With limitations
  - d. Other Practitioners' Services  
 Provided:  No limitations  With limitations
7. Home Health Services
- a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.  
 Provided:  No limitations  With limitations
  - b. Home health aide services provided by a home health agency.  
 Provided:  No limitations  With limitations
  - c. Medical supplies, equipment, and appliances suitable for use in the home.  
 Provided:  No limitations  With limitations
  - d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.  
 Provided:  No limitations  With limitations

\*Description provided on attachment.

IT No. 94-11  
 Superseded  
 IT No. 91-39      Approval Date MAY 16 1995      Effective Date JAN 1 - 1994

State/Territory: New York

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

8. Private duty nursing services.  
 Provided:  No limitations  With limitations\*
9. Clinic services.  
 Provided:  No limitations  With limitations\*
10. Dental services.  
 Provided:  No limitations  With limitations\*
11. Physical therapy and related services.
- a. Physical therapy.  
 Provided:  No limitations  With limitations\*
- b. Occupational therapy.  
 Provided:  No limitations  With limitations\*
- c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.  
 Provided:  No limitations  With limitations\*
12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
- a. Prescribed drugs.  
 Provided:  No limitations  With limitations\*
- b. Dentures.  
 Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TH No. 91-52  
Supersedes  
TH No. 86-30

Approval Date DEC 3 1981

Effective Date JUL 1

State/Territory: NEW YORK

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

- c. Prosthetic devices.  
 Provided:  No limitations  With limitations\*
- d. Eyeglasses.  
 Provided:  No limitations  With limitations\*
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.
- a. Diagnostic services.  
 Provided:  No limitations  With limitations\*
- b. Screening services.  
 Provided:  No limitations  With limitations\*
- c. Preventive services.  
 Provided:  No limitations  With limitations\*
- d. Rehabilitative services.  
 Provided:  No limitations  With limitations\*
14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services.  
 Provided:  No limitations  With limitations\*
- b. Skilled nursing facility services.  
 Provided:  No limitations  With limitations\*
- \*Description provided on attachment.

TN 93-49 Approval Date MAR 08 1995  
Supersedes TN 92-10 Effective Date SEP 1 - 1993

State/Territory: New York

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

- c. Intermediate care facility services.  
 Provided:  No limitations  With limitations\*
15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.  
 Provided:  No limitations  With limitations\*
- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.  
 Provided:  No limitations  With limitations\*
16. Inpatient psychiatric facility services for individuals under 22 years of age.  
 Provided:  No limitations  With limitations\*
17. Nurse-midwife services.  
 Provided:  No limitations  With limitations\*
18. Hospice care (in accordance with section 1905(o) of the Act).  
 Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No. 86-30  
Supersedes  
TN No. 85-30

Approval Date SEP 11 1990

Effective Date 01 OCT 1986

HCFA ID: 0140P/0102A

State/Territory: New York

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

19. Case management services and Tuberculosis related services
- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).
- Provided:  With limitations\*
- Not provided.
- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.
- Provided:  With limitations\*
- Not provided.
20. Extended services for pregnant women.
- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.
- Provided:  Additional coverage<sup>++</sup>
- b. Services for any other medical conditions that may complicate pregnancy.
- Provided:  Additional coverage<sup>++</sup>  Not provided.
21. Certified pediatric or family nurse practitioners' services.
- Provided:  No limitations  With limitations\*
- Not provided.
- + Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.
- ++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

\*Description provided on attachment.

94-39

TN No. \_\_\_\_\_  
Supersedes 94-14 Approval Date NOV 23 1994 Effective Date JAN 1 - 1994  
TN No. \_\_\_\_\_

State/Territory: New York

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

\*22. Respiratory care services (In accordance with section 1902(e)(9)(A) through (C) of the Act)

- Provided:                       No limitations                       With limitations\*
- Not provided.

\*23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

- Provided:                       No limitations                       With limitations\*
- Not provided.

b. Services provided in Religious Nonmedical Health Care Institutions.

- Provided:                       No limitations                       With limitations\*
- Not provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age.

- Provided:                       No limitations                       With limitations\*
- Not provided.

e. Emergency hospital services.

- Provided:                       No limitations                       With limitations\*
- Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

- Provided:                       No limitations                       With limitations\*
- Not provided.

\*Description provided on attachment

TN 01-40  
 Supersedes TN 91-39  
 Approval Date FEB 08 2002  
 Effective Date JAN 01 2002

TN No. 01-40  
 Supercedes 91-39 Approval Date FEB 08 2002 Effective Date JAN 01 2002  
 TN No. 87-47

\*22. Limitations on Respiratory Care Services may be rendered to EPST population and that service is furnished through the clinic and home benefits to this population.

\*23. For emergency outpatient services, utilization threshold clinic limitations apply.

State: New York

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO  
MEDICALLY NEEDY GROUP(S)

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Provided

Not provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

Provided:  State Approved (Not Physician) Service Plan Allowed

Services Outside the Home Also Allowed

Limitations Described on Attachment

Not Provided

26. Primary Care Case Management

Provided

Not Provided

TN NO. 00-43  
Supersedes  
TN

Approval Date

Effective Date OCT 01 2000

TN 00-43 Approval Date MAR 28 2000  
Supersedes TN New 94-49 → 92-71 Effective Date OCT 01 2000

7/11/01 SJ

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically  
Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in  
Supplement 3 to Attachment 3.1-A.

Election of PACE: By virtue of this submittal, the State elects PACE as an  
optional State Plan service.

No election of PACE: By virtue of this submittal, the State elects to not add  
PACE as an optional State Plan service.

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TN No.:

02-01

Supersedes:

Approval Date SEP 03 2002

Effective Date JAN 01 2002

TN NO.:

**New**

91-39

ATTACHMENT 11-B  
Supplement

*Prior App*

NEW YORK STATE - TITLE XIX STATE PLAN

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO MEDICALLY  
NEEDY GROUPS: all

NOTE: By prior approval, when indicated below, is meant that prior approval/authorization of the local professional director and/or the local social services commissioner is required for that service.

1. Inpatient care, services and supplies in a general hospital shall, in the case of a person admitted to such a facility on a Friday or Saturday, be deemed to include only those inpatient days beginning with and following the Sunday after such date of admission, unless such care, services and supplies are furnished for an actual medical emergency or pre-operative care for surgery as provided in paragraph (d) of subdivision five of section 365a of the Social Services Law, or are furnished because of the necessity of emergency or urgent surgery for the alleviation of severe pain or the necessity for immediate diagnosis or treatment of conditions which threaten disability or death if not promptly diagnosed or treated; provided, however, inpatient days of a general hospital admission beginning on a Friday or a Saturday shall be included commencing with the day of admission in a general hospital which the commissioner or his designee has found to be rendering and which continues to render full service on a seven day a week basis which determination shall be made after taking into consideration such factors as the routine availability of operating room services, diagnostic services and consultants, laboratory services, radiological services, pharmacy services, staff patterns consistent with full services and such other factors as the commissioner or his designee deems necessary and appropriate.

Inpatient care, services and supplies in a general hospital shall not include care, services and supplies furnished to patients for certain uncomplicated procedures which may be performed on an outpatient basis in accordance with regulations of the commissioner of health, unless the person or body designated by such commissioner determines that the medical condition of the individual patient requires that the procedure be performed on an inpatient basis.

1. Limits other than medical necessity are not applicable to EPSDT recipients in accord with 1905(r)5.
2. We have received the State Plan and reviewed it and determined that we are in compliance with EPSDT requirements

TN 91-39 Approval Date FEB 18 1992

Supersedes TN 85-30 Effective Date JUL 01 1991

*Amor*  
*APF*

4a. Prior approval is required for all out-of-state placements at Specialized Care Facilities for difficult to place individuals or High level Care facilities for the head injured.

Medicaid payments shall not be authorized for nursing facilities which are not certified or have not applied for certification to participate in Medicare.

Care days in nursing facilities is reimbursed for Medicaid patients requiring and receiving medically necessary lower level of care services. Medical Assistance is provided until such time as the appropriate level of care becomes available.

5. Prior approval is required for certain procedures which may be considered cosmetic or experimental. Physicians are informed of the specific prior approval requirements in the MMIS Physician Provider Manual.

6. Care and services will be provided only if they are in accordance with regulations of the Department of Health.

6a. Medicaid does not cover routine hygienic care of the feet in the absence of pathology.

Fee for service podiatry payments will only be made for services provided to Medicaid eligibles under twenty-one years of age under the EPSDT program and only by written referral from a physician, physician's assistant, nurse practitioner or certified nurse midwife.

Nursing facilities, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD's), and Article 28 or Article 31 inpatient facilities and certified clinics which include foot care services in the rate established for medical care for Medicaid recipients will continue to receive payments for these services through their rates. Additionally, Medicaid will continue to pay for medically necessary items and supplies (e.g., prescriptions drugs) for all recipients when ordered by a private practicing podiatrist.

In the office setting, a podiatrist may only provide a limited number of clinical laboratory tests. Podiatrists are informed of the specific clinical laboratory tests they may perform, in their office setting, in the MMIS Podiatrists Manual. A podiatrist may only provide radiological services which are within the scope of podiatric practice. Amputation and bunion surgery may be performed by a podiatrist in a hospital setting.

TN 93-52 Approval Date DEC 14 1993  
Supersedes TN 92-57 Effective Date JUL 1 - 1993

**OFFICIAL**

Attachment 3.1-B  
Supplement

**4b. Early and Periodic Screening, Diagnostic and Treatment services (EPSDT).**

School Supportive Health Services and Pre-School Supportive Health Services

School Supportive Health Services (SSHS) and Pre-School Supportive Health Services (PSSHS) are services provided by or through a school district, a Section 4201 school, a county in the State, or New York City to children with disabilities, who attend public or State Education Department approved schools or preschools. The services must be:

- medically necessary and included in a Medicaid covered category in accordance with 1905(a), 1905(r)(5), 1903(c) of the Social Security Act;
- ordered or prescribed by a physician or other licensed practitioner acting within his or her scope of practice under New York State Law;
- included in the child's Individualized Education Program (IEP);
- provided by qualified professionals under contract with or employed by a school district, a Section 4201 school, a county in the State or the City of New York;
- furnished in accordance with all requirements of the State Medicaid Program and other pertinent state and federal laws and regulations, including those for provider qualifications, comparability of services, and the amount, duration and scope provisions;  
and
- included in the state's plan or available under Early Periodic Screening, Diagnostic and Treatment (EPSDT) services.

Effective September 1, 2009, the services covered by the SSHS and PSSHS Program for Medicaid eligible children under the age of 21 who are eligible for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) include medically necessary physical therapy services, occupational therapy services, speech therapy services, psychological counseling, skilled nursing services, psychological evaluations, medical evaluations, medical specialist evaluations, audiological evaluations, and special transportation within the limits of EPSDT services. A school district, Section 4201 school, a county in the State, and New York City must be enrolled as a Medicaid provider in order to bill Medicaid.

**1. Physical Therapy Services**

**Definition:** Physical therapy services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

TN #09-61 \_\_\_\_\_  
Supersedes TN New \_\_\_\_\_

Approval Date Apr 26 2010  
Effective Date SEP 01 2009

OFFICIAL

Attachment 3.1-B  
Supplement

Services: Physical therapy services provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York, must have a written order or prescription from a physician, physician assistant, or nurse practitioner who is acting within the scope of his or her practice under NYS law and must be provided to a child by or under the direction of a qualified physical therapist. Physical therapy services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures necessary to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Physical therapy services include but are not limited to:

- Identification of children with physical therapy needs;
- Evaluation for the purpose of determining the nature, extent and degree of the need for physical therapy services;
- Provision of physical therapy services for the purpose of preventing or alleviating movement dysfunction and related functional problems;
- Obtaining, interpreting, and integrating information appropriate to program planning;
- Diagnosis and treatment of physical disability, injury or disease using physical and mechanical means, including but not limited to, heat, cold, light, air, water, sound, electricity, massage, mobilization and therapeutic exercise with or without assistive devices, and
- The performance and interpretation of tests and measurements to assist pathopsychological, pathomechanical and developmental deficits of human systems to determine treatment and assist in diagnosis and prognosis.

Physical therapy services may be provided in an individual or group setting.

Providers: Services must be provided by:

- a New York State licensed and registered physical therapist qualified in accordance with 42 CFR 440.110(a) and with applicable state and federal laws and regulations, acting within his or her scope of practice under New York State Law; or
- a certified physical therapy assistant "under the direction of" such a qualified licensed and registered physical therapist, acting within his or her scope of practice under New York State Law.

TN #09-61 \_\_\_\_\_  
Supersedes TN New \_\_\_\_\_

Approval Date APR 26 2010  
Effective Date SEP 01 2009

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Attachment 3.1-B  
Supplement

"Under the direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- sees the participant at the beginning of and periodically during the course of treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, at home and/or in community based settings.

**2. Occupational Therapy Services**

**Definition:** Occupational therapy services as outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Occupational therapy services provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must have a written order or prescription from a physician, physician assistant, or nurse practitioner who is acting within the

TN #09-61 \_\_\_\_\_  
Supersedes TN New \_\_\_\_\_

Approval Date APR 26 2010  
Effective Date SEP 01 2009

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Supplement**

scope of his or her practice under New York State Law and must be provided to a child by or under the direction of a qualified occupational therapist. Occupational therapy services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Occupational therapy services include but are not limited to:

- Identification of children with occupational therapy needs;
- Evaluation for the purpose of determining the nature, extent and degree of the need for occupational therapy services;
- Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;
- Preventing through early intervention, initial or further impairment or loss of function; and
- Planning and utilization of a program of activities to develop or maintain adaptive skills designed to achieve maximal physical and mental functioning of the student in daily life tasks.

Occupational therapy services may be provided in an individual or group setting.

**Providers:** Services must be provided by:

- a New York State licensed and registered occupational therapist qualified in accordance with 42CFR 440.110(b) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State Law; or
- a certified occupational therapy assistant (COTA) "under the direction of" such a qualified licensed and registered occupational therapist, within his or her scope of practice under New York State Law.

"Under the direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- sees the participant at the beginning of and periodically during the course of treatment;

TN #09-61 \_\_\_\_\_

Approval Date APR 26 2010

Supersedes TN New

Effective Date SEP 01 2009

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- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be rendered in the settings in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, 4201 schools, state operated schools, in private practitioner's offices, at home and/or in community based settings.

### **3. Speech Therapy Services**

**Definition:** Speech therapy services as outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Speech therapy services provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must have a written order or prescription from a physician, physician assistant, nurse practitioner, or a speech-language pathologist who is acting within his or her scope of practice under New York State law and must be provided to a child by or under the direction of a qualified speech-language pathologist. Speech therapy services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

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Speech therapy services include but are not limited to:

- Identification of children with speech disorders;
- Diagnosis and appraisal of specific speech disorders;
- Referral for medical or other professional attention necessary for the habilitation of speech disorders;
- Provision of speech or language services for the habilitation or prevention of communicative disorders.
- Evaluation and application of principles, methods and procedures of measurement, prediction, diagnosis, testing, counseling, consultation, rehabilitation and instruction, related to the development of disorders of speech, voice, and/or language, and
- Preventing, ameliorating or modifying speech disorder conditions in children and/or groups of children.

Speech therapy services may be provided in an individual or group setting.

**Providers:** Services must be provided by:

- a licensed and registered speech-language pathologist qualified in accordance with 42CFR Section 440.110(c) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law; or
- a teacher certified to provide speech and language services, under the documented direction of such a qualified licensed and registered speech language pathologist (ASHA-Certified or equivalent), acting within his or her scope of practice under New York State Law.

"Under the direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- sees the participant at the beginning of and periodically during the course of treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;

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- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, at home and/or in community based settings.

#### **4. Psychological Counseling**

**Definition:** Psychological counseling services outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Psychological counseling provided by or through a school district; a Section 4201 school; a county in the State or the City of New York must have a referral from a physician, physician assistant, or a nurse practitioner who is acting within the scope of his or her practice under NYS law or an appropriate school official or other voluntary health or social agency and must be provided to a child by or under the direction of a qualified practitioner. Psychological counseling services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Psychological counseling services include:

- treatment services using a variety of techniques to assist the child in ameliorating behavioral and emotional problems that are severe enough to require treatment.

Psychological counseling services may be provided in an individual or group setting.

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**Providers:** Psychological counseling services must be provided by a qualified practitioner, within his or her scope of practice in accordance with New York State Law and with the qualification requirements of 42 CFR Section 440.60(a) and 440.50(a)(2) and with other applicable state and federal laws or regulations. Psychological counseling services may only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological counseling services in the community.

Services may be provided by:

- a New York State licensed and registered psychiatrist qualified in accordance with 42 CFR Section 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law;
- a New York State licensed and registered psychologist qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law;
- a New York State licensed clinical social worker (LCSW), qualified in accordance 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law; or
- a licensed master social worker (LMSW) qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law, under the supervision of such a qualified licensed clinical social worker, a qualified licensed and registered psychologist, or a qualified licensed and registered psychiatrist as described above.

Supervision of the clinical social work services provided by the licensed master social worker, with respect to each Medicaid beneficiary, shall consist of contact between the licensed master social worker and supervisor during which:

- the licensed master social worker apprises the supervisor of the diagnosis and treatment of each client;
- the licensed master social worker's cases are discussed;
- the supervisor provides the licensed master social worker with oversight and guidance in diagnosing and treating clients;
- the supervisor regularly reviews and evaluates the professional work of the licensed master social worker; and
- the supervisor provides at least one hour per week or two hours every other week of in-person individual or group clinical supervision, provided that at least two hours per month shall be individual clinical supervision.

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Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, at home and/or in community based settings.

### **5. Skilled Nursing**

**Definition:** Skilled nursing services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Skilled nursing services provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York, must have a written order or prescription from a physician, physician assistant, or nurse practitioner acting within his or her scope of practice under New York State law and must be provided to a child by a registered nurse acting within his or her scope of practice under New York State law, or by a NYS licensed practical nurse acting within his or her scope of practice under New York State law "under the direction of" a NYS licensed and registered nurse or licensed physician, dentist or other licensed health care provider authorized under the Nurse Practice Act. Skilled nursing services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE) when there is a specific need based on a medical condition of the child.

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures necessary to correct and ameliorate physical defects, mental illnesses, and other disabilities.

Skilled nursing services include the promotion of health, prevention of illness, care of the ill and disabled people through the provision of services essential to the maintenance and restoration of health. Skilled nursing services may include:

- health assessments and evaluations;
- medical treatments and procedures;
- administering and/or monitoring medication needed by the student during school hours;  
and
- consultation with licensed physicians, parents and staff regarding the effects of medication.

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**Providers:** Skilled nursing services must be provided by:

- a New York State licensed registered nurse qualified in accordance with the requirements at 42 CFR 440.60(a) and other applicable state and federal law and regulations, acting within his or her scope of practice; or
- a New York State licensed practical nurse qualified in accordance with 42 CFR 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice "under the direction of" a licensed registered nurse, a physician, dentist or other licensed health care provider authorized under the Nurse Practice Act.

"Under the direction of" means that the licensed registered nurse, physician or other licensed health care provider authorized under the Nurse Practice Act:

- sees the participant at the beginning of and periodically during the course of treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be provided by:

- a New York State licensed and registered nurse; or
- a New York State licensed practical nurse, under the direction of a New York State licensed and registered nurse, or licensed physician, dentist or other licensed health care practitioner legally authorized under the Nurse Practice Act.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES)

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programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, and/or in community based settings.

## **6. Psychological Evaluations**

**Definition:** Psychological evaluations outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

Psychological evaluations provided by or through a school district; a Section 4201 school; a county in the State or the City of New York must have a referral from a physician, physician assistant, or nurse practitioner acting within his or her scope of practice under New York State law or an appropriate school official or other voluntary health or social agency and must be provided to a child by a qualified practitioner. Psychological evaluations must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a psychological evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

**Services:** Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Psychological evaluations include but are not limited to:

- Administering psychological tests and other assessment procedures;
- Interpreting testing and assessment results, and
- Evaluating a Medicaid recipient for the purpose of determining the needs for specific psychological, health or related services.

**Providers:** Psychological evaluations must be provided by a qualified provider who meets the requirements of 42 CFR Section 440.60 or 42 CFR Section 440.50(a) and other applicable state and federal laws and regulations. Psychological evaluation services may only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological evaluation services in the community.

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Services may be provided by:

- a New York State licensed and registered psychiatrist, qualified in accordance with 42CFR Section 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law; or
- a New York State licensed and registered psychologist, qualified in accordance with 42CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, and/or in community based settings.

## **7. Medical Evaluations**

**Definition:** Medical evaluations outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Medical evaluations provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must be performed by a physician, physician assistant, or nurse practitioner acting within the scope of his or her practice under New York State law. A medical evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a medical evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

A medical evaluation is the recording of:

- chief complaints;
- present illness;

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- past medical history;
- personal history and social history;
- a system review
- a complete physical evaluation;
- ordering of appropriate diagnostic tests and procedures, and
- recommended plan of treatment

**Providers:** A medical evaluation must be provided by a New York State licensed and registered, physician, physician assistant, or nurse practitioner qualified in accordance with 42 CFR Section 440.50(a), 440.60(a) and 440.166(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice under NYS law.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, and/or in community based settings.

### **8. Medical Specialist Evaluations**

**Definition:** Medical specialist evaluations outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct and ameliorate physical defects, mental illnesses, and other disabilities.

Medical specialist evaluations provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must be provided by a New York State licensed and registered physician, physician assistant, or nurse practitioner specialist acting within his or her scope of practice and related area of specialization. A medical specialist evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a medical specialist evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

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A medical specialist evaluation is:

- an examination of the affected bodily area or organ system and other symptomatic or related organ systems;
- the ordering of appropriate diagnostic tests and procedures, and
- the reviewing of the results and reporting on the tests and procedures.

**Providers:** A medical specialist evaluation must be provided by a qualified New York State licensed and registered physician, physician assistant, or nurse practitioner specialist practicing in the related area of specialization within his or her scope of practice under NYS law, in accordance with 42CFR Section 440.50(a), 440.60(a), and 440.166(a) and other applicable state and federal laws and regulations.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, and/or in community based settings.

## **9. Audiological Evaluations**

**Definition:** Audiological evaluations as outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Audiological evaluations provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must have a written order from a physician, physician assistant, or nurse practitioner who is acting within the scope of his or her practice under NYS law and provided to a child by a qualified practitioner. An audiological evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If an audiological evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct and ameliorate physical defects, mental illnesses, and other disabilities.

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Medically necessary audiology services include but are not limited to:

- Identification of children with hearing loss;
- Determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for the amelioration of hearing; and
- determination of the child's need for group and individual amplification.

An audiological evaluation is the determination of the range, nature and degree of hearing loss including:

- measurement of hearing acuity;
- tests relating to air and bone conduction;
- speech reception threshold;
- speech discrimination;
- conformity evaluations;
- pure tone audiometry.

Providers: Audiology evaluation services must be provided by a New York State licensed and registered audiologist, qualified in accordance with 42 CFR Section 440.60(a) and 42CFR Section 440.110(c)(3) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, and/or in community based settings.

### **10. Special Transportation**

Definition: Special transportation outlined in this section of the State Plan is available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct and ameliorate physical defects, mental illnesses, and other disabilities.

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Services: Special transportation provided by or through a school district; a Section 4201 school; a county in the State or the City of New York must be included in the IEP as recommended by the Committee on Special Education (CSE), or the Committee on Preschool Special Education (CPSE). Special transportation arrangements must be identified in the IEP.

Special transportation is provided when a child requires specialized transportation equipment, supports or services because of his/her disability as cited in 34 CFR 300.34(c)(16)(iii).

Special transportation is limited to those situations where the child receives transportation to obtain a Medicaid covered service (other than transportation), and both the Medicaid covered service and the need for special transportation are included in the child's IEP. Special transportation can only be billed on a day that a Medicaid reimbursable service was delivered and may only be billed at the rate for each one way trip.

Providers: Special transportation services must be provided by a qualified Medicaid provider. Attendance documentation (bus logs) is required in order to bill Medicaid. In order to receive payment for services provided to a Medicaid recipient, a vendor must be lawfully authorized to provide transportation services on the date the services are rendered.

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6d. Other Practitioner Services (Continued)

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Pharmacists as Immunizers

1. Reimbursement will be provided to pharmacies for vaccines and anaphylaxis agents administered by certified pharmacists within the scope of their practice.
2. Service setting.  
Services will be provided by a certified pharmacist in a pharmacy or in other locations where mass immunization may take place, such as retail stores/outlets, assisted living centers, and health fairs.
3. Provider qualifications.  
Pharmacists must be currently licensed, registered and certified by the NYS Department of Education Board of Pharmacy to administer immunizations.

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6d. Nurse Practitioners' Services

New York State covers all nurse practitioner specialties recognized under State Law with no limitations.

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- 6b. Prior approval is required for orthoptic training.
- 6c. Chiropractor services. Provision of chiropractic services shall be limited to EPSDT recipients by medical necessity. Services shall be provided to the extent that such services result from the referral of the recipient's physician or primary care clinic.
- 6d. Clinical psychologists. Provision of clinical psychology services shall require referral by:
1. The patient's personal physician or medical resource, such as a clinic, acting as the patient's physician;
  2. the medical director in an industrial concern;
  3. an appropriate school official;
  4. an official or voluntary health or social agency.

7a. Home care services are medically necessary services (physician order required) provided by a Certified Home Health Agency (CHHA) to individuals in the home and community. Such services include both part time and intermittent skilled health care and long-term nursing and home health aide services. Home (health) care services include nursing, home health aide, physical therapy, occupational therapy, and speech therapy. Patients must be assessed as being appropriate for intermittent or part-time nursing services ordered by a physician pursuant to a written plan of care provided by a home health agency upon admission to an Assisted Living Program (ALP), no later than 45 days from the date of admission, and at least once during each subsequent six month period. The social services district must review the assessment and prior authorize the service.

Providers of home (health) care services must possess a valid certificate of approval issued pursuant to the provisions of Article 36 of the Public Health Law, be certified in accordance with certified home health agency, long term home health care program and AIDS home care program certification and authorization and provide services in accordance with minimum standards.

Home (health) care services provider qualifications are provided for registered professional nurse, home health aide, physical therapist, occupational therapist and speech pathologist.

Registered professional nurse shall mean a person who is licensed and currently registered as a registered professional nurse pursuant to Article 139 of the New York State Education Law.

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The State assures the provision of Home Health services will be provided in accordance with 42 CFR 440.70.

- 7b. Patients must be assessed as being appropriate for home health aide services ordered by a physician pursuant to a written plan of care provided by a home health agency upon admission to an Assisted Living Program (ALP), no later than 45 days from the date of admission, and at least once during each subsequent six month period. The social services district must review the assessment and prior authorize the service.

Home Health aide shall mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care needs in his/her home. Home health aides shall have successfully completed a basic training program in home health aide services or an equivalent exam approved by the Department and possess written evidence of such completion.

Certified home health agencies may provide home health services to individual's diagnosed by a physician as having AIDS and are not required to hold a specific designation for providing home health services to AIDS patients.

Providers of AIDS home care services must possess a valid certificate of approval issued pursuant to the provisions of Article 36 of the Public Health Law (PHL), or a residential health care facility or hospital possessing a valid operating certificate issued under Article 28 of the PHL which is authorized under Article 36 of the PHL to provide an AIDS home care program; or an AIDS Center, specifically authorized pursuant to Article 36 of the PHL to provide an AIDS home care program, be certified in accordance with certified home health agency certification and authorization pursuant to sections 3606, 3611 and 3612 of PHL and provide services in accordance with minimum standards pursuant to section 3612 of PHL. Such an agency or program must participate as a home health agency under the provisions of Titles XVIII and XIX of the Federal Social Security Act.

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AIDS home care services providers qualifications are provided pursuant to Article 36 of the PHL.

The [S]state assures the provision of AIDS home care services will be provided in accordance with 42 CFR 440.70 (for the provision of home health services).

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**Home Telehealth Services**

Beginning on October 1, 2007, the Commissioner of Health is authorized to establish fees to reimburse the cost of home telehealth services provided by a certified home health agency, including those that provide AIDS home care services.

The Commissioner shall reimburse for telehealth services if such services are provided only in connection with federal Food and Drug Administration approved and interoperable devices, which are incorporated as part of a patient's plan of care.

The purpose of providing telehealth services shall be to assist in the effective monitoring and management of patients whose medical, functional, and/or environmental needs can be appropriately and cost-effectively met at home through the application of telehealth intervention.

Reimbursement for home telehealth services is to be provided for Medicaid patients with conditions or clinical circumstances associated with the need for frequent monitoring, and/or the need for frequent physician, skilled nursing or acute care services, and where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits or acute long term care facility admissions. Conditions or clinical circumstances shall include, but not be limited to, congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding.

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- 7c. Certain specialty items require prior approval. These items are identified for equipment dealers in the MMIS DME Provider Manual. Prior approval is required for most repairs to durable medical equipment. Personal Emergency Response Services (PERS) are provided according to [LDSS] Local Social Services District (LSSD) written authorization for recipients of personal care services and home health services ordered by a physician pursuant to a written plan of care.
- 7d. Physical therapist shall mean a person who is licensed by and currently registered with the New York State Education Department or who has been issued a valid limited permit by that Department. The state assures the provision of physical therapy services will be provided in accordance with 42 CFR 440.110(a)(2)(i) and 440.110(a)(2)(ii).

Occupational therapist shall mean a person who is registered with the American Occupational Therapy Association, or either a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association or a graduate of a curriculum in occupational therapy which is recognized by the World Federation of Occupational Therapists and is eligible for a registration with the American Occupational therapy Association. The state assures the provision of occupational therapy services will be provided in accordance with 42 CFR 440.110(b)(2)(i) and 440.110(b)(2)(ii).

Speech pathologist shall mean a person who is licensed as required by Article 159 of the New York State Education Law. The state assures the provision of speech therapy services will be provided in accordance with 42 CFR 440.110(c)(2).

8. Private Duty Nursing (PDN) is medically necessary nursing services, ordered by and in accordance with a written physician's treatment plan, provided in a person's home on a continuous basis normally considered beyond such nursing services available from a Certified Home Health Agency (CHHA) or intermittent nursing services normally provided through a CHHA but which are unavailable. Prior approval is required for private duty nursing services either in a person's home or in a hospital except in an urgent situation in which the attending physician may order the services for no more than two nursing days.

Care and services of a private duty nurse will be provided only if they are in accordance with the regulations of the Department of Health.

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Service providers who provide private duty nursing include a Licensed Home Care Services Agency's (LHCSA) registered nurses (RN) or licensed practical nurses (LPN) enrolled on an independent practitioner basis.

Nurses providing PDN must possess a license to practice in the State of New York and be currently registered by the New York State Education Department (NYSED). In addition, nurses providing an appropriate attestation regarding their training and ability to care for medically fragile children receive a Specialty code on their file entitling them to increased reimbursement for the provision of such care.

The [S]tate assures that the provision of PDN will be provided in accordance with 42 CFR 440.80.

9. Clinic services provided in Article 28 clinics are in accordance with 42 CFR §440.90 titled clinic services. Requirements for physicians supervision comply with the [S]tate Medicaid Manual, §4320B titled Physician Direction Requirement.

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**OFFICIAL**

- 2a. Prior authorization or dispensing validation is required for some prescription drugs. The State has established a preferred drug program with prior authorization for drugs not included on the preferred drug list. The prior authorization complies with the requirements of Section 1927 (d)(5) of the Social Security Act and provides for a 24-hour turnaround by either telephone or other telecommunications device from receipt of request and provides for a 72-hour supply of drugs in emergency circumstances. In addition, brand-name drugs that have a FDA approved, A-rated generic equivalent must be prior authorized unless exempted by the Commissioner of Health. Prior authorization is required for a generic equivalent of a brand name drug, including a generic equivalent that is on the preferred drug list or the clinical drug review program, when the net cost of the brand name drug, after consideration of all rebates, is less than the cost of the generic equivalent.

Drugs for which Medical Assistance reimbursement is available are limited to the following:

1. Outpatient drugs of any manufacturer which has entered into and complies with a rebate agreement under Sections 1902(a) (54) and 1927 (a) of the Act with the Centers for Medicare and Medicaid Services (CMS) which are prescribed for a medically accepted indication. All drugs covered by the National Drug Rebate Agreements remain available to Medicaid beneficiaries, although some may require prior authorization. Drugs for the treatment of erectile dysfunction, as set forth in 42 U.S.C. § 1396r-8(d)(2)(K), are not a covered service, on and after April 1, 2006, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and these uses have been approved by the Food and Drug Administration.
2. Supplemental Rebate Programs
 

The State is in compliance with Section 1927 of the Social Security Act. The State has the following policies for the Supplemental Rebate Programs for the Medicaid population.

  - a) CMS has authorized the State of New York to enter into the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the Amendment to the SRA submitted to CMS on March 30, 2006 have been authorized for pharmaceutical manufacturers' existing agreements through their current expiration dates. The updated NMPI SRA submitted to CMS on March 20, 2008 has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.
  - b) CMS has authorized the State of New York to enter into Medicaid State-specific Supplemental Rebate Agreement directly with manufacturers to receive supplemental rebates of covered outpatient drugs for Medicaid beneficiaries. The State-specific Supplemental Rebate Agreement was submitted to CMS on March 31, 2010 and has been authorized by CMS.
- [b] c) The prior authorization process complies with the requirements of Section 1927 of the Social Security Act and provides for a 24-hour turn-around response by either telephone or telecommunications device from the receipt of a prior authorization request. In emergency situations, providers may dispense a 72-hour supply of medications.
- [c] d) The terms of the supplemental rebate programs apply only to covered outpatient drugs for which the State is eligible for federal financial participation. Supplemental rebates received by the State in excess of those required under the National Drug Rebate Program will be shared with the Federal Government on the same percentage basis as applied under the National Drug Rebate Agreement.
- [d] e) Any [contracts] Supplemental Rebate Agreement not [approved] authorized by CMS will be submitted to CMS for [approval] authorization.
- [e] f) All drugs covered by the programs will comply with the provisions of the national drug rebate agreement.
3. Any changes to the NMPI Supplemental Rebate Agreement must be submitted to CMS for [approval] authorization. Any changes to the State-specific Supplemental Rebate Agreement NY State holds directly with the manufacturer must be submitted to CMS for authorization.
4. As provided by the Act, a new drug manufactured by a company which has entered into a rebate agreement may be covered subject to prior approval, unless the drug is subject to the allowable exclusion categories provided by the Act.
5. As specified in Section 1927(b)(3)(D) of the Act, notwithstanding any other provisions of law, rebate information disclosed by a manufacturer shall not be disclosed by the state for purposes other than rebate invoicing and verification.

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[2.]6. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

[3.]7. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit -Part D.

X The following excluded drugs are covered:

- (a) agents when used for anorexia, weight loss, weight gain
- (b) agents when used to promote fertility
- (c) agents when used for cosmetic purposes or hair growth
- X (d) agents when used for the symptomatic relief cough and colds: Some—benzonatate only
- X (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride: Some—select B Vitamins (niacin, pyridoxine, thiamine, cyanocobalamin); Folic Acid; Vitamin K; Vitamin D (ergocalciferol, cholecalciferol); Iron (including polysaccharide iron complex); Iodine
- X (f) nonprescription drugs: Some—select allergy, asthma and sinus products; analgesics; cough and cold preparations; digestive products; insulin; feminine products; topical products; smoking cessation products, minerals and vitamin combinations
- (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- X (h) barbiturates: All
- X (i) benzodiazepines: All
- X (j) smoking cessation for non-dual eligibles as Part D will cover: All

12b. Prior approval is required for all dentures.

12c. Prior approval is required for prosthetic and orthotic devices over a dollar amount established by the State Department of Health and identified for providers in the MMIS DME Provider Manual.

Prior approval is required for artificial eyes as specified in the MMIS Ophthalmic Provider Manual.

Program also includes coverage of orthotic appliances including hearing aids. All hearing aids require prior approval.

12d. Prior approval is required for certain special lenses and unlisted eye services as specified for providers in the MMIS Ophthalmic Provider Manual.

13a. Diagnostic Services (see 13.d Rehabilitative Services - Early Intervention).

13b. Screening Services (see 13.d Rehabilitative Services - Early Intervention).

13c. Preventive Services (see 13.d Rehabilitative Services - Early Intervention).

13d. Rehabilitative Services

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(1) Directly Observed Therapy (DOT) – Clients must be assessed as medically appropriate for DOT based upon the client’s risk of non adherence to a medication regimen necessary to cure an active, infectious, potentially fatal disease process and to prevent the development and spread of an infectious, potentially fatal disease which may not respond to conventional therapies.

“Off-site” services shall be provided to developmentally disabled persons whose therapeutic requirements are most effectively satisfied in an appropriate environment that is specific to the treatment needs of the developmentally disabled individual. Such services shall be provided by persons authorized pursuant to NYCRR Title 14 Part 679. “Off-site” services shall not be provided at the location of a clinic certified by NYCRR Title 14 Part 679.

“Early Intervention” Services are provided to children who have or who are suspected of having a developmental delay or disability. These services, limited to EPSDT, which are provided by or on behalf of a county or the City of New York pursuant to an Individualized Family Services Plan (IFSP) include:

- |                       |  |   |
|-----------------------|--|---|
| 1. Screening          | 6. Occupational Therapy  | 11. Speech Pathology Services                         |
| 2. Evaluation         | 7. Physical Therapy  | 12. Assistive Technology Services                     |
| 3. Audiology          | 8. Psychological Services  | 13. Vision Services                                   |
| 4. Nursing            | 9. Social Work Services  | 14. Collateral contacts for all of the above services |
| 5. Nutrition Services | 10. Anticipatory Guidance<br>(Special Instruction and Allied Health Professional Assistance) |   |

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13.d (Cont'd) Rehabilitative services for residents of community-based residential programs licensed by the Office of Mental Health (OMH) are of three types:

1. Community residences of sixteen beds or less;
2. Family-based treatment and
3. Teaching family homes.

1. Community Residences

Rehabilitative services in community residences are interventions, therapies and activities which are medically therapeutic and remedial in nature, and are medically necessary for the maximum reduction of functional and adaptive behavior deficits associated with the person's mental illness. Community residences for adults may be either a congregate-type arrangement or apartment-based. Community residence services are also provided to children.

Limitations on services include the following:

- All providers must be currently licensed by OMH as community residences under 14 NYCRR 586 and 594. Congregate locations have sixteen beds or less.
- Adults admitted must be determined to have a severe and persistent mental illness, as defined by the Commissioner of OMH.
- Children admitted must be determined to have a serious emotional disturbance, as defined by the Commissioner of OMH.
- Services are limited to those described in 14 NYCRR 593.
- All services must be provided pursuant to a physician's written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593.

2. Family-based treatment

Rehabilitative services in family-based treatment programs are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child's developmental stage. Those children determined eligible for admission are placed in surrogate family homes for care and treatment.

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Limitations on services include the following:

- all providers must be currently licensed by OMH as family-based treatment programs under 14 NYCRR 594.
- children admitted must be determined to have a serious emotional disturbance, as defined by the Commissioner of OMH.
- services are limited to those described in 14 NYCRR 593.
- all services must be provided pursuant to a physician's written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593.

### 3. Teaching Family Homes

Rehabilitative services in teaching family homes are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child's developmental stage. Eligible children are placed in small congregate care homes (4 children or less) in a supervised living arrangement with approved teaching parents, based on the National Teaching Family Model.

This program is different from family based treatment because some children are not able to tolerate the family closeness of family based treatment programs, and, therefore, are more appropriately treated in teaching family homes.

Limitations on services include the following:

- All providers must be currently licensed by OMH as teaching family homes under 14 NYCRR 594.
- Children admitted must be determined to have a serious emotional disturbance, as defined by the Commissioner of OMH.
- Services are limited to those described in 14 NYCRR 593.
- All services must be provided pursuant to a physician's written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593.

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Page 3b-1

4. Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) programs will provide case management, treatment and rehabilitation to persons with a serious psychiatric disorder who exhibit a pattern of institutional utilization and/or are at risk of a severely dysfunctional lifestyle; present symptoms and impairments not effectively remedied by other available treatment; do not or cannot be engaged in treatment in other outpatient settings as a result of their mental illness; or cannot maintain consistency in treatment through other outpatient services.

Programs will be licensed under 14 NYCRR Part 508. Services will be provided primarily in the community. Services will be provided under the supervision of a psychiatrist by a multi-disciplinary team which meets with the recipient or the recipient's significant others a minimum of six times per month. Of these six contacts, at least three of the contacts must be with the Medicaid recipient. Step down services may be provided to clients found by the team to be no longer in need of full ACT team services. A client who is receiving ACT step down must receive a minimum of two face to face contacts per month. Individuals shall be allowed to alternate between the full ACT team services and step-down services depending on the level of services needed to remain in the community.

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APP**OFFICIAL**Attachment 3.1-B  
Supplement'  
Page 3b-2**13 d. Rehabilitative Services**  
**Personalized Recovery Oriented Services**

A comprehensive Personalized Recovery Oriented Services (PROS) program will provide Community Rehabilitation and Support, Intensive Rehabilitation and Ongoing Rehabilitation and Support. A "limited license" will be made available for free-standing Intensive Rehabilitation and Ongoing Rehabilitation and Support programs that are operated by a provider that does not have the capability to offer Community Rehabilitation and Support.

Community Rehabilitation and Support (CRS) is designed to engage and assist individuals in managing their mental illness and in restoring those skills and supports necessary to live successfully in the community. Intensive Rehabilitation (IR) is a customized package of rehabilitation and support services designed to intensely assist an individual in attaining specific life goals such as successful completion of school, attainment of stable and independent housing, and gainful employment. Intensive Rehabilitation services may also be used to provide targeted interventions to reduce the risk of hospitalization, loss of housing, involvement in the criminal justice system, and to help individuals manage their symptoms. Ongoing Rehabilitation and Support (ORS) will provide interventions designed to assist in managing symptoms in a an integrated workplace setting.

PROS programs will offer a comprehensive menu of services, customized for each client through development of an individualized recovery plan. Services provided by the CRS component of a PROS program will include but are not limited to: engagement; assessment; wellness self-management; basic living skills training; benefits and financial management; community living skills exploration; crisis intervention; individual recovery planning; information and education regarding self help; and structured skill development and support. Services provided by the IR component of a PROS program will include but are not limited to: family psychoeducation; intensive rehabilitation goal acquisition; clinical counseling and therapy; and intensive relapse prevention. Service provided in the IR component of a "limited license" PROS program will include, but is not limited to, intensive rehabilitation goal acquisition for employment and education-oriented goals. Services provided by the ORS component of a PROS program will include, but are not limited to, vocational support services, defined as the ongoing provision of counseling, mentoring and advocacy services designed to sustain an individual's role in integrated employment by providing supports which assist the individual in symptom management. PROS services will be provided both onsite and offsite, but ORS services will always be provided off-site in the community.

Programs may, at their option, provide clinical treatment services designed to stabilize, ameliorate and control the disabling symptoms of mental illness. Programs that provide clinical treatment services will be reimbursed at a higher rate for the clinic component than programs which do not provide clinical treatment services.

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**13 d. Rehabilitative Services**  
**Personalized Recovery Oriented Services-continued**

The goal of the program is to provide integrated services, but clients can choose to receive services from different service components in more than one program. Clients enrolled in a PROS program which provides clinical treatment services will also be given free choice as to whether they wish to receive clinical treatment through the PROS program, or receive those services from a clinic licensed under 14 NYCRR Part 587.

Programs will be licensed and reimbursed under criteria set forth in 14 NYCRR Part 512. Staffing requirements will include differing staff to client ratios depending on the component of services the program offers.

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Rehabilitative Services (cont.)

"Off-site" services shall be provided to developmentally disabled persons whose therapeutic requirements are most effectively satisfied in an appropriate environment that is specific to the treatment needs of the developmentally disabled individual. Such services shall be provided by persons authorized pursuant to NYCRR Title 14 Part 679. "Off-site" services shall not be provided at the location of a clinic certified by NYCRR Title 14 Part 679.

18. Limitations on Hospice Services:

Hospice services are provided to individuals who are certified [Recipients must be diagnosed] by a physician as being terminally ill, [that is, having] with a life expectancy of approximately six months or less [to live].

Recipients must sign an informed consent electing hospice over conventional care, subject to periodic review.

Services [must be] provided [in accordance with pertinent Department of Health regulations are palliative in nature as opposed to curative; Services include supportive medical, social, emotional, and spiritual services to terminally ill individuals as well as emotional support for family members. Hospice services may be delivered at home, in a nursing home or in a hospice residence.

Recipients who elect hospice care waive all rights to Medicaid reimbursement made on their behalf for the duration of the election of any services covered under the Medicaid State Plan that are related to the treatment of the terminal condition for which hospice care was elected, or a related condition.

Hospice services provider qualifications are provided for registered professional nurse, home health aide, physical therapist, occupational therapist, speech pathologist, personal care aide, housekeeper/homemaker, pastoral care coordinator, social worker, nutritionist, audiologist, and respiratory therapist, personal care aid, housekeeper/homemaker, pastoral care coordinator, social workers, nutritionist, audiologist, and respiratory therapist.

Registered professional nurse shall mean a person who is licensed and currently registered as a registered professional nurse pursuant to Article 139 of the New York State Education Law.

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Home Health aide shall mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care needs in his/her home. Home health aides shall have successfully completed a basic training program in home health aide services or an equivalent exam approved by the Department and possess written evidence of such completion.

Physical therapist shall mean a person who is licensed by and currently registered with the New York State Education Department or who has been issued a valid limited permit by that Department.

Occupational therapist shall mean a person who is registered with the American Occupational Therapy Association, or either a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association or a graduate of a curriculum in occupational therapy which is recognized by the World Federation of Occupational Therapists and is eligible for a registration with the American Occupational Therapy Association.

Speech pathologist shall mean a person who is licensed as required by Article 159 of the New York State Education Law.

Personal care aide shall mean a person who, under professional supervision, provides patients assistance with nutritional and environmental support and personal hygiene, feeding and dressing and/or, as an extension of self-directed patients, selects health-related tasks. A personal care aide shall have successfully completed:

- (i) a training program in home health aide services or equivalent exam as specified in the description for home health aide above; or
- (ii) one full year of experience in providing personal care services through a home care services agency within three years preceding the effective date of an initial license issued pursuant to Article 36 of the Public Health Law; or
- (iii) a training program in personal care services approved by the New York State Department of Health, which shall include basic training, periodic and continuing in-service training, and on-the-job instruction and supervision; and

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3(c)(ii)

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in those instances where the personal care aide is to be providing assistance with health-related tasks, such aide shall be trained as described in subparagraph (iii) of this paragraph and training in health-related tasks shall be completed in full prior to the personal care aide's assignment to any patient, as evidenced by written documentation of such completion.

Homemaker shall mean a person who meets the standards established by the Department of Social Services and assists and instructs persons at home because of illness, incapacity or absence of a caretaker relative in providing assistance with environmental and nutritional tasks.

Pastoral care coordinator shall mean a person who has had a minimum of one year of training and experience in pastoral/spiritual counseling, and has a baccalaureate degree from a regionally accredited college or university or one recognized by the New York State Department of Education.

Social worker shall mean a person who holds a master's degree in social work after successfully completing a prescribed course of study at a graduate school of social work accredited by the Council on Social Work Education and the Education Department, and who is certified or licensed by the Education Department to practice social work in the State of New York. When employed by a certified home health agency, long-term home health care program or hospice, such social worker must have had one year of social work experience in a health care setting.

Nutritionist shall mean a person who applies the principles of normal and therapeutic nutrition and of the physical, biological, social and behavioral sciences to the assessment and management of those factors in the personal community environment which influence nutritional status. A nutritionist must possess a baccalaureate degree, with major studies in food and nutrition, from a regionally accredited or New York State registered four-year college or university, and be registered or be eligible for registration by the American Dietetic Association.

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Audiologist shall mean a person who is licensed as required by Article 159 of the New York State Education Law.

Respiratory therapist shall mean a person who is licensed and currently registered as a respiratory therapist pursuant to Article 164 of the New York State Education Law.

Providers of Hospice Services must be certified in accordance with Article 40 of the PHL. Services are provided in accordance with 42 CFR Part 418.

The State assures the provision of Hospice services will be provided in accordance with 42 CFR Part 418.

19. Limitations on Tuberculosis related services:

Directly Observed Therapy (DOT) – will be provided to clients who are being treated for Tuberculosis Disease.

22. Limitation on Respiratory Care:

Services may be rendered to EPSDT population by medical necessity and that services is furnished through the clinic and home benefits to this population.

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- 23a. Prior approval is required for non-emergent transportation, including the services and subsistence of the attendant. Requests can be made by recipients or their family members; or medical practitioners acting on behalf of a recipient.

Transportation providers are assigned to requests for non-emergency transportation services based upon first, a recipient's choice of available participating vendors at the medically appropriate level of transportation; then, if the recipient indicates no preference, the ordering practitioner's choice among available participating vendors at the medically appropriate level of transportation; and finally, if no choice is made by the ordering practitioner, the request is given via rotation among the medically available and appropriate mode of transportation providers.

1. To assure comparability and statewideness, each county's local department of social services manages transportation services on behalf of recipient's assigned to the county.
2. Recipient, family member, or volunteer reimbursement is made as an administrative expense of the Medicaid Program. This applies to any personal vehicle mileage reimbursement, lodging, airfare, or other expense borne on behalf of the Medicaid recipient by a non-direct vendor.

- 23d. Prior approval is required for skilled nursing facility services except when admitted directly from a hospital, another skilled nursing facility or from a health related facility.

Medicaid payments shall not be authorized for skilled nursing facilities which are not certified or have not applied for certification to participate in Medicare.

25. Personal care services means some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Prior approval is required for all personal care services. The authorization period and amount of personal care services authorized depends upon patient need, as indicated in the patient's assessment.

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3(d)(A)

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Personal care services, shared aide and individual aide, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.

Providers of personal care services (personal care aides) must have:

- maturity, emotional and mental stability, and experience in personal care or homemaking;
- the ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records;
- a sympathetic attitude toward providing services for patients at home who have medical problems;
- good physical health, as indicated by the documentation in the personnel file of all persons providing personal care services. This documentation must include the same assurances and proof of good physical health that the Department of Health requires for employees of certified home agencies;
- a criminal history record check performed to the extent required under section 124 of the PHL; and
- successfully completed a training program approved by the Department.

Personal care aides must be supervised by a registered professional nurse who is licensed and currently certified to practice in New York State and who has at least two years satisfactory recent home health care experience. Nursing supervision includes orienting the personal care aide to his/her job assignment(s); providing needed on-the-job training; making nursing supervisory visits to the patient's home PRN, but at least every 90 days; and, annually conducting an overall job performance evaluation of the aide.

New York State's Personal Care Services are provided in accordance with 42 CFR 440.167.

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3(d)(i)

**OFFICIAL**

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Supplement  
(07/07)

**25 (cont.). Consumer Directed Personal Assistance Program**

The Consumer Directed Personal Assistance Program (CDPAP) is a consumer directed home care services delivery model. The program serves Medicaid recipients who have a medical need for home care services and who choose to participate in this model. It has operated under the State's Personal Care Services benefit since 1990. As such, the eligibility, assessment and prior authorization of services processes mirror that of the Personal Care Services Program (PCSP). In the traditional PCSP, the local social services district (LSSD) contracts with home care agencies for the provision of services. The home care agency is responsible for hiring, training, supervising, and providing the home care worker with salary and benefits. In the CDPAP a local social services district contracts with a CDPAP agency and there is a co-employer relationship between the CDPAP agency and the consumer that encompasses these functions. The CDPAP consumer is responsible for hiring/training/supervising/and firing his/her aides. The CDPAP agency acts as the co-employer of each aide hired by the consumer for the purpose of setting wage levels and fringe benefits, including health insurance coverage and other benefits, e.g. unemployment and workers compensation. It is the CDPAP agency that actually pays each aide and administers related fringe benefits. The CDPAP agency also submits claims for payment to the Department's agent that processes and pays claims for services provided to Medicaid recipients.

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26. The State elects to provide medical assistance services to eligible individuals through a Primary Care Case Management Program. PCCMs are responsible for locating, coordinating, and monitoring covered primary care to all individuals enrolled with a case manager.

PCCM providers may be physicians, physician group practices, entities employing or having other arrangements with physicians to provide PCCM Services under the contract. Nurse practitioners may also be a PCCM provider.

A PCCM will provide for arrangements with, or referrals to a sufficient number of physicians and other appropriate health care professional to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

PCCMs are required to be accessible 24 hours/seven days per week to provide information, referral and treatment to enrollees. PCCMs may not restrict an enrollees access to emergency services, or require prior authorization of emergency services.

A PCCM shall be geographically accessible to enrollees. Primary care providers must meet State standards for travel time and distance.

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TN

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APP*

General

- a) Prior approval of the local professional director shall be required for medical care and services which are to be provided outside New York State, except in the following situations:
  - 1. When it is customary for the inhabitants of the district generally to use medical care resources and facilities outside New York State.
  - 2. When out-of-state care was provided in an emergency.
- b) When a request subject to prior approval has been modified or denied in whole or in part because of disagreement with the proposed plan of treatment, recipients are notified that they may request a fair hearing.

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Page 5

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Supplement  
(04/05)

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES  
PROVIDED TO THE CATEGORICALLY NEEDY

In addition to the limitations specified on pages 1 through 4 regarding services,  
the following limitations also apply to the noted services:

2a.; 2b.; 2c.; 2d.;

Services will be provided in accordance with the utilization threshold requirements described in departmental regulations, which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

3. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations, which are based on medical necessity and identified for providers in the MMIS Laboratory Provider Manual. Such threshold requirements are applicable to specific provider service types including laboratories. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.
5. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations, which are based on medical necessity and identified for providers in the MMIS Physician Provider Manual. Such threshold requirements are applicable to specific provider service types including physicians, for services furnished in the office or patient's home. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

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A utilization threshold service is decremented each time a patient is seen by a physician including those times when the patient is seen by a physician and an electronic prescription/fiscal order is transmitted for medically necessary pharmaceuticals and select over the counter medications.

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Supplement  
(10/06)**

9. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.
- 11a. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provisions of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.
- 11b. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess or prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

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New York

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**Attachment 3.1-B  
Supplement  
(10/06)**

- 11c. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.
- 12a. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Pharmacy Provider Manual. Such threshold requirements are applicable to specific provider service types including pharmacy for prescription items and their refills, over the counter medications, and medical/surgical supplies dispensed by a community or outpatient pharmacy. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

TN #06-61 \_\_\_\_\_

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JUN 10 2010

JAN 01 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM

Attachment 3.1-C

State of New York

OFFICIAL 74 2 P. 1

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

The following is a description of the methods that will be used to assure that the medical care and services are of high quality, and a description of the standards established by the State to assure high quality care:

- a. Medical assistance will be provided in accordance with the individual's medical needs based on the prescription or recommendation of the attending physician, dentist or other licensed practitioner eligible to participate in the program.
- b. All professional persons providing service must be properly licensed under State Law. For certain paramedical services such as occupational therapy, speech therapy, etc., where there are no State licensing requirements, the persons providing such services must be qualified or certified by the appropriate national professional association.
- c. Medical institutions such as hospitals, nursing homes, etc; health related facilities such as intermediate care facilities, medical facilities such as clinics, private laboratories, etc.; and health agencies (such as community visiting nurse associations) which provide care to recipients in the medical assistance program must be licensed or approved by the appropriate State authority.
- d. Services ordinarily interpreted to be specialist's procedures or care must be provided by practitioners who are qualified specialists.
- e. Home nursing services provided must conform to standards approved by the State Department of Health.
- f. For certain care or services the recommendation of an appropriate specialist is required. (i.e., the more unusual prosthetic devices, rehabilitation therapies, orthodontic care, etc.).
- g. Requirement that each local welfare district establish and maintain an adequate system of individual patient medical records showing diagnoses and services provided.
- h. Collection of other medical information such as, at the State level, expenditures for various items of medical care and gross utilization data by categories. At the local level similar expenditure data related to individual medical attendants and vendors, and utilization data, particularly for physicians and hospital care. Drug records for individual patients are also maintained in a number of local welfare districts.

N.Y. Tr. 3/20/74 Incorp. 12/31/74 Effective 1/1/74

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1937 (STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
Medical Assistance Program

State: New York

**Section 3 – Services: General Provisions**

**3.1 Amount, Duration, and Scope of Services**

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1902(z), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act; section 245(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483

**C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).**

The State elects to provide alternative benefits:

- Provided
- Not Provided

<input checked="" type="checkbox"/> Title of Alternative Benefit Plan A- Medication Therapy Management (MTM) Program
<input type="checkbox"/> Title of Alternative Benefit Plan B

**1. Populations and geographic area covered**

The State will provide the benefit package to the following populations:

- a)  Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, that may be required to enroll in an alternative benefit plan to obtain medical assistance.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the state will require to enroll in the alternative benefit plan;
- Each eligibility group the state will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

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~~new~~

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Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	X	Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	See Box Below	Bronx County
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
	X	Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • • • •	See Box Below	Bronx County
	X	Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)	See Box Below	Bronx County
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
	X	Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)	See Box Below	Bronx County
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)		
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: • • • •		

Targeting Criteria:  
The MTM program will provide focused one-on-one, face-to-face medication management by a qualified pharmacist to Medicaid enrollees (voluntarily enrolled) to improve overall health outcomes and to decrease overall healthcare costs.

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Asthma will be the initial chronic medical condition to be addressed in the Medicaid MTM program. Beginning as a pilot program, MTM will be offered to Medicaid enrollees with continuous coverage under Medicaid for the last 180 days and who are ages 21-63 with asthma, living in the Bronx. Excluded from the program are dual eligible Medicaid/Medicare enrollees, institutionalized enrollees and managed care enrollees.

The MTM program will be offered to eligible individuals meeting program criteria.

Medicaid enrollees will be identified as eligible for MTM services using the following selection criteria, based on an analysis of Medicaid medication claims and other Medicaid paid claims including hospital and emergency room claims. This group will be refined to contain patients with persistent asthma by applying determinants of disease severity based on resource utilization or suboptimal chronic therapy. All target enrollees must have at least one asthma related hospital or emergency room visit during the past year or suboptimal chronic medication therapy related to asthma.

b) . The following populations will be given the option to voluntarily enroll in an alternative benefit plan.

Please indicate in the chart below:

- Each eligibility group the state will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included group (e.g., income standard).
- Specify the geographic area in which each group will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X	Mandatory categorically needy low-income parents eligible under 1931 of the Act	Same as Section 1a.	Bronx County
X	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):	Same as Section 1a.	Bronx County
X	Basic TWWIA working individuals with disabilities eligible under 1902(a)(10)(A)(ii)(XV)	Same as Section 1a.	Bronx County
X	Individuals qualifying for Medicaid on the basis of blindness under:	Same as Section 1a.	Bronx County
X	Individuals qualifying for Medicaid on the basis of disability under:	Same as Section 1a.	Bronx County
X	Individuals eligible for Social Security benefits under title XVIII of the Act (Health Insurance for the Aged and Disabled)	Same as Section 1a.	Bronx County
	Individuals who are terminally ill and receiving Medicaid hospice benefits		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
	Individuals dually eligible for Medicare and Medicaid		

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Children younger than age 19 who are eligible for SSI		
Disabled children eligible under the TEFRA option - section 1902(e)(3)		
Children receiving foster care or adoption assistance under title IV-E of the Act		
Children in foster care or other out-of-home placement		
Children receiving non-IV-E foster care or adoption assistance		
Individuals receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V of the Act (Maternal and Child Health Services Block Grant)		
Individuals who qualify based on medical condition for Medicaid coverage of institutional or community-based long-term care services		
Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		
Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)		

- c) For optional populations/individuals (checked above in 1a. & 1b.), describe in the text box below the manner in which the State will inform each individual that:
- Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State plan.

The New York State Medicaid program is sending an invitation letter to all eligible enrollees residing in the Bronx stating MTM services are available and enrollment is voluntary. Enrollees are also advised that if they choose to enroll in the MTM program, they may opt out of this program at any time. Invitation letters and enrollment materials will be available in Spanish. All State Plan services will continue to be included for enrollees opting to participate in the MTM program; no State Plan services will be excluded.

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2. Description of the Benefits

The State will provide the following alternative benefit package (check the one that applies).

a)  Benchmark Benefits

**FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(1) of Title 5, United States Code.

**State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved.

In the text box below please provide either a World Wide Web URL (Uniform Resource Locator) link to the State's Employee Benefit Package or insert a copy of the entire State's Employee Benefit Package.

**Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved.

In the text box below please provide either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

**Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State plan or to services in any of the three Benchmark plans above

1) The new State Plan service, MTM, will be available to all eligible enrollees, identified in this SPA, residing in the Bronx meeting specific State defined inclusion criteria.

MTM services will be provided in addition to all State Plan services. These services will continue to be included for enrollees opting to participate in the MTM program; no State Plan services will be excluded.

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DEC 16 2009

JUN 11 2009

2) Medication Therapy Management will provide one-on-one, face-to-face medication therapy services provided by trained, qualified NYS Medicaid MTM pharmacists who possess a New York State pharmacy license. The services will be rendered in Medicaid enrolled retail pharmacies that have received a NYS Medicaid MTM-designation. Asthma will be the initial chronic medical condition to be addressed in the Medicaid MTM program. The services to be provided include:

- o patient assessment (medical history as related by the patient);
- o comprehensive patient medication therapy review;
- o personal medication record (retained by the patient);
- o medication action plan (for the patient to follow);
- o assistance in finding a primary care physician (if needed);
- o documentation of problems, resolutions, education and evaluation of patient response to medication therapy including adverse events; and
- o follow-up to ensure patient adherence with medication action plan and;
- o encourage patient self-management.

Enrollees will be provided MTM services from State trained, qualified Medicaid MTM pharmacists performing within their scope of practice pursuant to NYS Education Law. Pharmacists will not be providing medical advice to enrollees but will be conferring with the enrollee's prescriber to share recommendations. These pharmacists are expected to also facilitate linkage of the enrollee with a primary care provider (PCP) when the enrollee does not have a PCP.

3) Enrollee choice and consent

The MTM program will be offered to eligible individuals meeting program criteria. Enrollee eligibility for MTM services is based on specific inclusion criteria developed by the New York State Medicaid program described in the targeting criteria. Eligible enrollees will be invited to voluntarily opt into the Medicaid MTM program and will receive notification containing the name and contact information for Medicaid MTM-designated pharmacies in their area. The notification will encourage the enrollee to contact the Medicaid MTM-designated pharmacy of their choice to set up their initial visit.

Medicaid enrollees who agree to participate in the MTM program will be required to sign a consent form, prior to the enrollee's first visit with a qualified Medicaid MTM pharmacist, releasing identifiable health information to practitioners and pharmacists involved in the enrollee's care and MTM program. Enrollees receiving MTM services may choose to change either their Medicaid MTM designated pharmacy, change their qualified Medicaid MTM pharmacist at any time or opt out of MTM services at any time.

4) Service setting

Services will be provided face-to-face by a qualified pharmacist in an area of a Medicaid MTM-designated community pharmacy separate from the dispensing area to afford privacy for discussion of the enrollee's medical and pharmaceutical issues. MTM services will only be available at designated MTM pharmacies in the Bronx.

5) Frequency of service

Enrollees will be eligible for one initial visit and 6 subsequent visits per 12 month period.

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*New*

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6) Provider qualifications

Medicaid MTM-designated Pharmacies- In order to participate in the MTM program, a pharmacy must: (1) be licensed and registered and in good standing with the Department of Education Board of Pharmacy, (2) be enrolled and in good standing with the NYS Medicaid program, (3) provide a current (and updated, as required) list of qualified MTM pharmacist(s) in its employment and (4) provide a separate and private MTM counseling area.

Qualified Medicaid MTM Pharmacists- In order to participate in the New York State Medicaid MTM program, a pharmacist must: (1) be registered and in good standing with the State Department of Education Board of Pharmacy and (2) be in good standing with the NYS Medicaid program and (3) have completed the NYS Medicaid MTM training.

b)  Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to:

[Empty rectangular box for specifying benchmark plans]

(i)  Inclusion of Required Services – The State assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

- Inpatient and outpatient hospital services;
- Physicians' surgical and medical services;
- Laboratory and x-ray services;
- Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;
- Other appropriate preventive services including emergency services and family planning services included under this section.

(ii)  Additional services

Insert a full description of the benefits in the plan including any limitations.

[Empty rectangular box for describing additional services]

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*new*

- (iii) N/A The State assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:
  - Has been prepared by an individual who is a member of the American Academy of Actuaries;
  - Using generally accepted actuarial principles and methodologies;
  - Using a standardized set of utilization and price factors;
  - Using a standardized population that is representative of the population being served;
  - Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
  - Takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

Insert a copy of the report.

iv N/A The State assures that if the benchmark plan used by the State for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following four categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State:

- Prescription drugs;
- Mental health services;
- Vision services, and/or
- Hearings services,

In the text box below provide a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c Additional Benefits

Insert a full description of the additional benefits including any limitations.

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- Other Additional Benefits (If checked, please describe)

3. Service Delivery System

Check all that apply.

- The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.
- The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t).
- The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR 438, 1903(m), and 1932).
- The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR 438.
- The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).
- The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished.

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 \_\_\_\_\_

4. Employer Sponsored Insurance

- The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

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**New**

5. Assurances

N/A The State assures EPSDT services will be provided to individuals under 21 years old who are covered under the State Plan under section 1902(a)(10)(A).

Through Benchmark only

As an Additional benefit under section 1937 of the Act

X The State assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

All modes of transportation are available to Medicaid enrollees, when necessary to access care and service covered under the Medicaid Program. Medicaid transportation is an optional item of medical assistance, per New York Social Services Law at § 365-a. Implementation of this law is found at Title 18 New York Code of Rules and Regulation at section 505.10 and is on file in New York's State Plan.

6. Economy and Efficiency of Plans

X The State assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

8. Implementation Date

X The State will implement this State Plan amendment on | January 6, 2010 | (date).

TN#: 09-08

Supersedes TN#: new

Approval Date:

DEC 16 2009

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JUN 11 2009

**new**

Provisions for Providing  
Medical Assistance Transportation

**OFFICIAL**

The following provisions set forth the Department's policy concerning transportation services provided to Medical Assistance (MA) recipients for the purpose of obtaining necessary medical care and services which can be paid for under the MA program. These provisions set forth the standards which the Department will use in determining when the MA program will pay for transportation and describes the prior authorization process for obtaining payment.

The MA program covers all modes of transportation, including, but not limited to: emergency ambulance and non-emergency modes of transportation. Transportation is provided by service providers at Department-established fee schedules set at levels where the Department can successfully assure the availability of medically necessary transportation to services covered by the MA program.

A. Prior Authorization

1. Prior authorization is required for the following:

- a. all transportation to obtain medical care and services, except emergency ambulance transportation or Medicare approved transportation by ambulance service provided to an MA-eligible person who is also eligible for Medicare Part B payments.
- b. transportation expenses of an attendant for the MA recipient.

The provisions set forth the standards to be used in evaluating prior authorization requests and provides the prior authorization official (i.e., the Department, the county department of social services, or their designated agents) with the authority to approve or deny reimbursement to MA recipients for the use of private vehicles (personal cars) or mass transportation which the recipient uses for the usual activities of daily living. A prior authorization official may approve reimbursement for the use of personal cars or mass transportation, however, if, in the opinion of the prior authorization official, circumstances so warrant. A prior authorization official may also approve reimbursement for the use of some other mode of transportation, such as ambulance, wheelchair or stretcher van, or taxi/livery, as required by the MA recipient.

2. Criteria to be used by the prior authorization official in making prior authorization determinations are:

- a. the MA recipient has access to necessary medical care or services by use of a private vehicle or by means of mass transportation which is used by the recipient for the usual activities of daily living;
- b. the frequency of visits or treatments within a short period of time whereby the recipient would suffer financial hardship if required to make payment for the transportation;
- c. the nature and severity of the MA recipient's illness which necessitates transportation by a mode other than that ordinarily used by the MA recipient (such as an acute event wherein an otherwise ambulatory recipient becomes physically disabled);
- d. the geographic locations of the MA recipient and the provider of medical care and services;
- e. the medical care and services available within the common medical marketing area of the MA recipient's community;
- f. the need to continue a regimen of medical care or service with a specific provider; and,
- g. any other circumstances which are unique to a particular MA recipient and which the prior authorization official determines have an effect on the need for payment of transportation services.

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Effective Date: MAR 26 2009

The decision to require the MA recipient to travel using a personal vehicle, public transit, or taxi is made by the prior authorization official based upon the prior authorization official's knowledge of personal vehicle ownership and the local public transit routes. When a more specialized mode of transportation is required, such as wheelchair or stretcher van, or ambulance, the prior authorization official will make a decision on the proper mode of transport after consideration of information obtained from a medical practitioner, supervisors, the Department, program guidance materials, and any other source available, that will help the official to make a reasoned decision.

B. Payment

1. Criteria to be used when establishing payment for medical assistance transportation:
  - a. Social services districts have the authority to establish payment rates with vendors of transportation services which will ensure the efficient provision of appropriate transportation for MA recipients in order for the recipients to obtain necessary medical care or services. Social services districts may establish such rates in a number of ways, which may include negotiation with the vendors. However, no established rate will be reimbursed unless that rate has been approved by the Department as the Department established rate.
    - i. The State defines "department established rate" as the rate for any given mode of transportation which the department has determined will ensure the efficient provision of appropriate transportation to MA recipients in order for the recipients to obtain necessary medical care and services.
    - ii. The department may either establish rate schedules at which transportation services can be assured or delegate such authority to the social services districts. Delegation of authority exists only in episodic circumstances in which immediate transportation is needed at a cost not considered in the established fee schedule. In order to ensure access to needed medical care and service, the social services districts will approve a rate to satisfy the immediate need.
    - iii. Plans, rate schedules or amendments may not be implemented without departmental approval.
    - iv. Social services districts have no authority to establish a fee schedule without the Department's involvement; there is no incongruity between the Department's and social services district's fee schedules.
    - v. Payment for reimbursement of the MA recipient's personal vehicle will be made at the Internal Revenue Service's established rate for Medical Mileage. Payment of reimbursement for use of a personal vehicle of a volunteer driver or family member of a MA recipient will be made at the Internal Revenue Service's established rate for Standard Mileage.
  - b. Payment for transportation is only available for transportation to and from providers of necessary medical care and services which can be paid for under the MA program. MA payment for transportation will not be made if the care or services are not covered under the MA program.
  - c. MA payment to vendors of transportation services is limited to situations where an MA recipient is actually being transported in the vehicle.
  - d. MA payment will not generally be made for transportation which is ordinarily made available to other persons in the community without charge. If federal financial participation is available for the costs of such transportation, the MA program is permitted to pay for the transportation.
  - e. Vendors of transportation services must provide pertinent cost data to a social services district upon request or risk termination from participation in the MA program.

Finally, the provisions require social services districts to notify applicants for and recipients of MA of the procedures for obtaining prior authorization of transportation services.

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JAN 19 2010

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Effective Date:

MAR 26 2009

State/Territory: New York

**STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES**

-Organ and tissue transplantation services must be performed in hospitals approved by the Commissioner of Health and the hospital must be a member of the Organ Procurement and Transplantation Network approved by the Secretary, U.S. Department of Health and Human Services and must abide by its rules and requirements.

-The hospital must participate in a patient registry program with an organ procurement organization designated by the Secretary, U.S. Department of Health and Human Services.

-The hospital must ensure that written policies are developed and that the written criteria used for the selection of patients for transplant services must be consistent with professional standards of practice and applied consistently.

-Chapter 589 of the Laws of 1990 amended the Public Health Law to provide for more equitable access to donated organs. To ensure equitable access to human organs to persons in need of transplants:

- Each Organ Procurement Organization (OPO) must maintain a single waiting list for each type of organ and the policies and procedures for distributing organs to potential recipients must take into account patient factors such as tissue type.
- No OPO designated to serve any part of New York State shall place any person on a waiting list for the allocation of organ(s) for transplantation if that person is listed on another waiting list for the same organ. The OPO must insure that the patient is not already listed by another OPO.
- Each facility performing transplant services shall inform every transplant candidate that no patient may place his or her name on a waiting list maintained by an OPO designated to serve any part of New York State if the person is listed on any other waiting list maintained by another such OPO.

-The hospital must maintain a record of all patients who are referred for transplantation and the date of their referral, the results of the evaluation of all candidates for transplantation which documents the reasons a candidate is determined to be either suitable or unsuitable for transplantation, the date suitable candidates are selected for transplantation, the date the transplantation surgery occurred, the organs utilized, and the donor.

NY No. 92-58  
Supersedes  
NY No. 87-47

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**OFFICIAL**

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Condition or Requirement

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A. Section 1932(a)(1)(A) of the Social Security Act.

The State of New York enrolls Medicaid beneficiaries into managed care entities (managed care organizations (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

In April 2007, the New York legislature authorized the Department of Health (DOH) to establish Chronic Illness Demonstration Projects (CIDPs) to test models of care management and coordination to address the complex health and social needs of Medicaid fee-for-service recipients with complex behavioral and medical health conditions. Enrollment into the program will be voluntary in select geographic areas across the state.

NY DOH will award a contract to a CIDP entity that will function as the overall Primary Care Case Management entity. Each CIDP entity will be responsible for ensuring the provision of primary care services in accordance with 1905(t)(1). CIDP entities will be responsible for the following functions: locate eligible beneficiaries; complete an initial health assessment and periodic reassessments; develop and update a care/service plan; coordinate care/discharge/referral among multiple providers; maintain state-specified frequency of contact (telephonic and in-home/provider office) with beneficiaries; and report specified process and outcome measures.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)  
1932(a)(1)(B)(ii)  
42 CFR 438.50(b)(1)

1. The State will contract with an

i. MCO

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Citation	Condition or Requirement
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	<p><input checked="" type="checkbox"/> ii. PCCM (including capitated PCCMs that qualify as PAHPs)</p> <p><input type="checkbox"/> iii. Both</p> <p>2. The payment method to the contracting entity will be:</p> <p><input checked="" type="checkbox"/> i. fee for service;</p> <p><input type="checkbox"/> ii. capitation;</p> <p><input checked="" type="checkbox"/> iii. a case management fee;</p> <p><input checked="" type="checkbox"/> iv. a bonus/incentive payment;</p> <p><input type="checkbox"/> v. a supplemental payment, or</p> <p><input checked="" type="checkbox"/> vi. other. (Please provide a description below).</p> <p>Contractors will be at-risk for a portion of the monthly care coordination fee (MCCF) if quality, reporting and performance standards are not achieved. Any necessary recoupment of the MCCF will be withheld from future payments due to the contractor, and the federal portion of the recoupment will be returned to CMS.</p> <p>In addition, the DOH will make available funds for shared cost savings incentive payments. Only contractors that have meet all quality, reporting and performance standards will be eligible to participate in the shared savings. Shared savings incentive payments will not exceed 105% of the aggregate payment for Medicaid services received.</p> <p>Reconciliation of at- risk and shared savings will be done annually, after the first contract year.</p>
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	<p>3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.</p> <p>If applicable to this state plan, place a check mark to affirm the state has met <i>all</i> of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).</p> <p><input checked="" type="checkbox"/> i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.</p> <p><input checked="" type="checkbox"/> ii. Incentives will be based upon specific activities and targets.</p>

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Citation	Condition or Requirement
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- iii. Incentives will be based upon a fixed period of time.
- iv. Incentives will not be renewed automatically.
- v. Incentives will be made available to both public and private PCCMs.
- vi. Incentives will not be conditioned on intergovernmental transfer agreements.
- vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (*Example: public meeting, advisory groups.*)

The demonstrations are to be established by a competitive procurement or discretionary grant. Prior to the development of the RFP document the DOH Office of Health Insurance Programs (OHIP) consulted with many stakeholders, including: New York State (NYS) DOH public health experts in chronic disease; sister agencies such as the Office of Mental Health (OMH) and the Office of Alcohol and Substance Abuse Services (OASAS); experts in public health policy; experts in Medicaid quality improvement; public health research scientists; and medical and behavioral health providers. The purpose of this collaboration was to solicit input and expertise to assist in the design of a solicitation document that would support the development of CIDP programs that would address the complex needs of this population and fulfill the intent of the legislation. Based on the input received, the RFP document was developed and made available for comment to many of the aforementioned entities.

In accordance with procurement regulations, an advertisement was placed in the "New York State Contract Reporter" informing the public that the CIDP RFP was to be released. The RFP and supportive documentation were also made available on the DOH website. Interested parties and potential bidders were sent letters via both the US Postal system and electronic mail informing them of the release of the RFP and inviting them to the Pre-Bid Conference. The Pre-Bid Conference, held after the RFP release, offered interested parties and potential bidders an opportunity to seek clarification and ask questions regarding the solicitation. All questions and answers discussed at the Pre-Bid Conference or submitted post-Conference were made public on the DOH website and sent to all interested parties, potential bidders and those entities that had submitted a letter of interest. A press release was issued from

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the Commissioner of Health, with supportive comments from both the Commissioners of OMH and OASAS, promoting the goals and availability of funding for the CIDPs. In accordance with the guidelines for bidder proposal submission evaluation and selection, applicants were competitively selected for contract award.

During the implementation and operations of the CIDPs DOH will maintain a highly collaborative and coordinated working relationship with each of the CIDP programs. During the course of the demonstrations there will be opportunities for stakeholders to provide ongoing feedback. For example, DOH will conduct semiannual multistakeholder collaborative meetings to foster learning, information sharing, problem solving and to provide technical assistance to the CIDPs. Medical and behavioral providers, social service agencies, community based organization, local government, OMH and OASAS representatives staff and other interested parties will also be included in the collaborative sessions. Additionally, DOH will solicit input on a quarterly basis at the Medicaid Advisory Committee meetings.

1932(a)(1)(A)

5. The state plan program will \_\_\_/will not  implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory \_\_\_/ voluntary  enrollment will be implemented in the following county/area(s):

i. county/counties (mandatory) \_\_\_\_\_

ii. county/counties (voluntary)  See county list- 5.iv.

iii. area/areas (mandatory) \_\_\_\_\_

iv. area/areas - (by(voluntary)  Portions of these counties

Albany  
Bronx  
Erie  
Kings  
Nassau  
New York  
Queens  
Rensselaer

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Saratoga  
Schenectady  
Suffolk  
Westchester

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)  
1903(m)  
42 CFR 438.50(c)(1)

1.  The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)  
1905(t)  
42 CFR 438.50(c)(2)

2.  The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1902(a)(23)(A)

1932(a)(1)(A)  
42 CFR 438.50(c)(3)

3.  The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A)  
42 CFR 431.51  
1905(a)(4)(C)

4.  The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)  
42 CFR 438  
42 CFR 438.50(c)(4)  
1903(m)

5.  The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

1932(a)(1)(A)  
42 CFR 438.6(c)  
42 CFR 438.50(c)(6)

6.  The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

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Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. ___ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

**D. Eligible groups**  
**Enrollment will be voluntary**

- 1932(a)(1)(A)(i)
1. List all eligible groups that will be enrolled on a mandatory basis.
  2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.  
Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
    - i. \_\_\_ Recipients who are also eligible for Medicare.  
  
If enrollment is voluntary, describe the circumstances of enrollment.  
*(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
    - ii. \_\_\_ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
    - iii. \_\_\_ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
    - iv. \_\_\_ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
    - v. \_\_\_ Children under the age of 19 years who are in foster care or other out-of-
- 1932(a)(2)(B)  
42 CFR 438(d)(1)
- 1932(a)(2)(C)  
42 CFR 438(d)(2)
- 1932(a)(2)(A)(i)  
42 CFR 438.50(d)(3)(i)
- 1932(a)(2)(A)(iii)  
42 CFR 438.50(d)(3)(ii)
- 1932(a)(2)(A)(v)

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State: New York

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Citation	Condition or Requirement
42 CFR 438.50(3)(iii)	the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ___ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ___ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

**E. Identification of Mandatory Exempt Groups**

***Enrollment will be voluntary; children under age 19 are excluded***

- 1932(a)(2)  
42 CFR 438.50(d)
1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (*Examples: children receiving services at a specific clinic or enrolled in a particular program.*)
2. Place a check mark to affirm if the state's definition of title V children is determined by:
- i. program participation,
  - ii. special health care needs, or
  - iii. both
- 1932(a)(2)  
42 CFR 438.50(d)
3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.
- i. yes
  - ii. no
- 1932(a)(2)  
42 CFR 438.50 (d)
4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (*Examples: eligibility database, self-identification*)
- i. Children under 19 years of age who are eligible for SSI under title XVI;
  - ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

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Citation	Condition or Requirement
	iii. Children under 19 years of age who are in foster care or other out-of-home placement;
	iv. Children under 19 years of age who are receiving foster care or adoption assistance.
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. ( <i>Example: self-identification</i> )
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: ( <i>Examples: usage of aid codes in the eligibility system, self-identification</i> )  i. Recipients who are also eligible for Medicare.  ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
42 CFR 438.50	F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u> <b>Enrollment will be voluntary</b>
42 CFR 438.50	G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u>  The eligible group for voluntary enrollment includes disabled Medicaid FFS recipients, exempt or excluded from managed care, who are medically and behaviorally complex and receive services across multiple provider agencies, and: <ul style="list-style-type: none"><li>• Have full Medicaid coverage,</li><li>• Have multiple co-morbid chronic conditions, such as, but not limited to: asthma, cardiovascular disease, chronic kidney disease and end stage renal</li></ul>

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State: New York

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Citation	Condition or Requirement
	<p>failure, congestive heart failure, coronary atherosclerosis, diabetes, history of acute myocardial infarctions, HIV/AIDS, hypertension, obstructive pulmonary disease, and sickle cell anemia;</p> <ul style="list-style-type: none"><li>• Are 19 years of age or older;</li><li>• Are within the geographic catchments area of the CIDP;</li><li>• May have mental illness and chemical dependence, either singularly or co-occurring;</li><li>• May be in the Recipient Restriction Program;</li><li>• May be homeless;</li><li>• May be a Native American;</li><li>• Are not dually eligible for Medicare and Medicaid;</li><li>• Are not enrolled in a Managed Care Plan, Special Needs Plan, Managed Long Term Care Plan, or Family Health Plus;</li><li>• Are not residing in a State-operated psychiatric center or free standing psychiatric hospital, Intermediate Care Facility, Residential Health Care Facility, Skilled Nursing Facility, Alcohol and Substance Abuse or Chemical Dependence Long Term Residential treatment program, or hospice;</li><li>• Are not in receipt of Medicaid Home and Community Based Waiver (HCBW) services; and</li><li>• Are not individuals who have a documented diagnosis of mental retardation or a developmental disability based on NYS Mental Hygiene Law.</li></ul>

H. Enrollment process

*Not Applicable (no default enrollment)*

1932(a)(4)  
42 CFR 438.50

1. Definitions

- i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.
- ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)  
42 CFR 438.50

2. State process for enrollment by default.

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TN No. New

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State: New York

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Citation	Condition or Requirement
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Describe how the state's default enrollment process will preserve:

- i. the existing provider-recipient relationship (as defined in H.1.i).
- ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).
- iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). (Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)

1932(a)(4)  
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:
  - i. The state will \_\_\_/will not \_\_\_ use a lock-in for managed care managed care.
  - ii. The time frame for recipients to choose a health plan before being auto-assigned will be \_\_\_\_\_.
  - iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. (Example: state generated correspondence.)
  - iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. (Examples: state generated correspondence, HMO enrollment packets etc.)
  - v. Describe the default assignment algorithm used for auto-assignment. (Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)

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State: New York

Citation Condition or Requirement

This provision is not applicable to this 1932 State Plan Amendment.

4.          The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

This provision is not applicable to this 1932 State Plan Amendment.

5.          The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)  
42 CFR 438.50

J. Disenrollment

1. The state will          /will not  use lock-in for managed care.
2. The lock-in will apply for          months (up to 12 months).
3. Place a check mark to affirm state compliance.

The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)  
42 CFR 438.50  
42 CFR 438.10

The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)  
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**STATE NEW YORK**  
**COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII**

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

- 1.  Individuals receiving SSI under title XVI or State supplication, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement Systems are included:

Yes  No

- 2.  Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included.

Yes  No

- 3.  All individuals eligible under the State's approved title XIX plan.
- 4.  Qualified Medicare beneficiaries provided by section 301 of PL.100-360 as amended by section §434 of PL.100-647.

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

Qualified Medicare beneficiaries provided by section 301 of PL. 100-360 as amended by section §434 of PL.100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups.

- 1. Qualified Medicare beneficiaries provided by section 301 of PL.100-360 as amended by section §434 of PL.100-647.

- 2. All Title XIX recipients covered under Part A or B of Title XVIII and eligible for Part A or B services covered by Medicaid.

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MARCH 1987

ATTACHMENT 3.2-A  
Page 2  
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

[Dual eligibles (Medicaid and Medicare eligible) who are not Qualified Medicare Beneficiaries: The MA program will pay on behalf of MA recipients who are not qualified Medicare beneficiaries the full amount of any deductible and coinsurance costs incurred under Part B of Title XVIII of the Social Security Act, provided that such costs were incurred for care, services or supplies included in the MA Program.]

TN 03-38

DEC 24 2003

Superseding TN 93-28

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87-47

STATE PLAN UNDER TITLE XIX OF THE  
SOCIAL SECURITY ACT - ATTACHMENT 4.11-A

STATE OF NEW YORK

STANDARDS FOR INSTITUTIONS AND SUPPLIERS OF SERVICES

Department of Health

Citation: 10 NYCRR, HEALTH, Volume A  
Chapter II Administrative Rules and Regulations  
Subchapter D Laboratories

Part

58 Clinical Laboratories and Blood Banks

Citation: 10 NYCRR, HEALTH, Volume A-1  
Subchapter J Controlled Substances

Part

80 Rules and Regulations on Controlled Substances

Subchapter K Hospitals and Related Facilities

Part

81 Residential Health Care Facilities: Patient Abuse

82 Hospital Survey Planning and Review

83 Shared Health Facilities

85 Medical Assistance-Benefits

Subchapter L X-ray Technology and Chiropractic Use of X-ray

Part

89 Practice of X-ray Technology

Subchapter M Physician's Assistance, Prohibited Discrimination in Hospital  
Staff Appointments and Privileges

Part

94 Physician's Assistants and Specialist's Assistants

Subchapter N Practice of Nursing Home Administration and Home Nursing  
and Health Services and Agencies

Part

96 Licensure and Practice of Nursing Home Administration

86-7  
supersedes

74-14

74-2

Approval Date MAY 07 1986 Effective Date JAN. 01 1986

Subchapter P Health Maintenance Organization

Part

98 Health Maintenance Organization

Department of Health

Citation: 10 NYCRR HEALTH, Volume C  
Chapter V Medical Facilities  
Subchapter A Medical Facilities - Minimum Standards

Article 1 General

Part

- 400 All Facilities--General Requirements
- 401 All Facilities--Operating Certificates

Article 2 Hospitals

Part

- 405 Hospitals--Minimum Standards

Article 3 Residential Care Facilities

Part

- 410 Respite Demonstration Projects
- 411 Ombudsmen Access to Residential Health Care Facilities
- 412 Reporting Information for Inspections
- 413 Consumer Information System
- 414 General Minimum Standards

Article 4 Nursing Homes

Part

- 415 Organization and Administration
- 416 Patient Services

Article 5 Health-Related Facilities

Part

- 420 Organization and Administration
- 421 Resident Services

Article 6 Skilled Nursing and Health-Related Services; Non-Occupants

Part

- 425 General Provisions
- 426 Organization and Administration
- 427 Registrant Services

86-7  
superseded  
94-14 + 74-2

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Article 7 Home Health Agencies: Treatment Centers and Diagnostic Centers

Part

- 430 Certified Home Health Agencies
- 431 Treatment Centers and Diagnostic Centers

Subchapter B Hospital Establishment

Part

- 600 General Provisions
- 610 Special Requirements for Non-profit Corporations
- 620 Incorporations and Transfers of Proprietary Businesses
- 630 Special Requirements for Local Governmental Applicants
- 640 Procedures for Approval of the Development of Comprehensive Health Services and the Establishment of Such Facilities
- 650 Dissolution of Corporations
- 660 Public Health Council Approval of Maintenance Programs
- 670 Determination of Public Need for Medical Facility Establishment

Subchapter C State Hospital Code

Article 1 General Provisions

Part

- 700 General
- 702 Environmental Health
- 703 Ambulatory Services
- 705 New Medical Technology and Health Services Demonstration Projects
- 706 Special Diagnostic and Therapeutic Services
- 707 Physician's Assistants and Specialist's Assistants
- 708 Appropriateness Review
- 709 Determination of Public Need for Medical Facility Construction

Article 2 Medical Facility Construction

Part

- 710 Approval of Medical Facility Construction
- 711 General Standards for Construction
- 712 Standards of Construction for New Hospitals
- 713 Standards of Construction for New Nursing Homes
- 714 Standards of Construction for New Health-Related Facilities
- 715 Standards of Construction for New Diagnostic or Treatment Facilities
- 716 Standards of Construction for New Rehabilitation Facilities

86-7  
supersedes  
74-14 + 74-2

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Article 3 Hospital Operation

Part

720 Maximum Standard

86 7

Article 4 Residential Health Care Facility Operation

Part

730 Organization and Administration  
731 Patient Services  
732 Penalties  
733 Consumer Information System  
734 Ombudsmen Access to Residential Health Care Facilities

Article 5 Health-Related Facility Operation

Part

740 Organization and Administration  
741 Resident Services  
742 Penalties

Article 6 Treatment Centers and Diagnostic Center Operation

Part

750 General Provisions  
751 Organization and Administration  
752 Medical Staff Organization  
753 Maternal, Child Health and Newborn Services  
754 Family Planning Services  
755 Free-Standing Ambulatory Surgery Centers

Article 7 Certified Home Health Agencies

Part

760 Establishment  
761 Certification  
762 Approval of Construction  
763 Organization and Administration  
764 Patient Services  
765 Approval and Licensure of Home Care Services Agencies  
766 Licensed Home Care Services Agency Organization and Administration  
767 Licensed Home Care Services Agency Patient Services  
770 Long Term Home Health Care Program  
771 Organization and Administration of Long Term Home Health Care Programs

86-7  
supersedes  
74-14 & 74-2

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Article 8 Residential Health Care Facility Services for Nonoccupants

Part

- 780 General Provision
- 781 - Organization and Administration
- 782 Registrant Services

Chapter VI Emergency Services

Part

- 800 General

86-7

supersedes

74-14 274-2

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Department of Mental Hygiene  
Citation: 14 NYCRR, MENTAL HYGIENE, Volume A  
Chapter I General

Part

- 4 Residential Care for Mentally Retarded Persons Pending Admission to State Schools
- 8 Public Access to Records of Department of Mental Hygiene and the Facilities in the Department
- 9 Procedure under Article 730 of the Criminal Procedure Law

Chapter II All Facilities  
Subchapter A Admission and Transfer of Patients

Part

- 15 Admission and Retention of Patients
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74-14 + 74-2

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- 82 Operation of Hospitals for the Mentally Ill
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- 201 Pilot Clinic Programs for Treatment of Drug Addiction
- 202 Special Facilities Certified by the Commissioner for Drug Addicts

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Chapter X Alcoholism

86 7

Part

- 303 Public Access to Records
- 304 Designation of Emergency Care Services for Intoxicated Persons and Persons Incapacitated by Alcohol
- 305 Preventive Counseling Services for Children of Alcoholics or Alcohol Abusers
- 306 Incidents at Facilities for Alcoholism and Alcohol Abuse
  
- 330 Program Standards for Medical Ambulatory Services for Alcoholism
- 368 Declaratory Rulings
- 369 Appeals and Hearings
- 395 Alcoholism Counselors

Department of Mental Hygiene

Citation: 14 NYCRR, MENTAL HYGIENE, Volume B  
Chapter XIII Office of Mental Health

Part

- 540 Patients Committed to the Custody of the Commissioner Pursuant to CPL Article 730
- 541 Defendants Committed to the Custody of the Commissioner Pursuant to CPL Section 330.20
- 542 Safety Standards for Securing Firearms and Ammunition
- 561 Use of Space
- 575 Community Support Services for the Mentally Ill
- 583 Pre-admission Certification Committees for Residential Treatment Facilities for Children and Youth
- 584 Operation of Residential Treatment Facilities for Children and Youth
- 585 Operation of Outpatient Programs for the Mentally Ill
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Chapter XIV Office of Mental Retardation and Developmental Disabilities

Part

- 676 Diagnostic and Research Clinics
- 679 Medicaid Assistance Payment for Ambulatory Services for the Developmentally Disabled
- 680 Specialty Hospital
- 681 Operating Standards for Intermediate Care Facilities
- 688 Personal Care Services for Developmentally Disabled Persons Residing in Foster Homes and Community Residences
- 690 Operating Standards for Day Treatment Programs for Persons who are Developmentally Disabled

Chapter XX Commission on Quality of Care

Part

- 700 Commission on Quality of Care for the Mentally Disabled

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Chapter XXV Division of Substance Abuse Services

Part

- 1000 General
- 1010 Approval of Substance Abuse Services
- 1020 Requirements for the Operation of All Substance Abuse Programs
- 1030 Requirements for the Operation of Drug-Free Substance Abuse Programs
- 1040 Requirements for the Operation of Chemotherapy Substance Abuse Programs
- 1060 Public Access to Records

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DEPARTMENT OF SOCIAL SERVICES

Citation: 18 NYCRR, SOCIAL SERVICES, VOLUME B  
Chapter II Regulations of the Department of Social Services  
Subchapter C Social Services  
Article 2 Family and Children Services

86 7

Part

428 Standards for Uniform Case Records and Child Service Plans

Article 3 Child Care Agencies

Part

- 441 General
- 442 Institutions
- 443 Certified and Approved Foster Family Boarding Homes—Agency Procedure for Certification, Approval and Supervision
- 444 Requirements for Licensed, Certified and Approved Foster Family Boarding Homes
- 447 Agency Boarding Homes
- 448 Group Homes
- 449 Supervised Independent Living
- 451 Group Emergency Foster Care

Article 5 Operating Certificates - Children's Facilities

Part

- 476 General
- 477 Issuance of Operating Certificates

Article 6 Certificates of Incorporation: Miscellaneous Corporate Matters

Part

- 481 General
- 482 Approval of Certificates of Incorporation
- 483 Miscellaneous
- 484 Development and Improvement of Community Facilities

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UTILIZATION CONTROL IN INTERMEDIATE CARE FACILITIES

1. Utilization control in intermediate care facilities is provided through facility-based reviews.
2. Utilization control in intermediate care facilities for the mentally retarded is through review by NYS OMRDD, Division of Quality Assurance staff, as well as independent organizations under contract with NYS OMRDD.

MP/arb  
MP-2-11

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Attachment 4.16-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MEDICAL ASSISTANCE PROGRAM

STATE OF NEW YORK

Summary of Cooperative Arrangements with State Health and State Vocational  
Rehabilitation Agencies and with Title V Grantees:

## COOPERATIVE AGREEMENT

## BY AND BETWEEN

The State Department of Health, hereinafter referred to as "Health" and the State Department of Social Services, hereinafter referred to as "Social Services".

## WITNESSETH:

WHEREAS, On July 30, 1965, the "Social Security Amendments of 1965" were enacted into law as Public Law 89-97, which among its provisions included the enactment of Title XIX making additional funds available to the states for Medical Assistance provided to eligible individuals; and

WHEREAS, Title XIX makes provision for the submission of a "State plan" by a "single State agency";

WHEREAS, Chapter 256 of the Laws of 1966, added a new Title 11 to Article 5 of the Social Services Law (sections 363, et seq.) promoting the State's goal of making available to everyone regardless of race, age, national origin, or economic standing, uniform high quality medical care, makes provisions for a program of Medical Assistance for Needy Persons, hereinafter referred to as "Medical Assistance" and designated Social Services the "single State agency" for purposes of Title XIX; and

WHEREAS, such a State plan heretofore has been developed by Social Services pursuant to Title XIX and Title 11 and has been submitted to, and approved by, the Health Care Financing Administration (HCFA), the federal agency responsible for administration of Title XIX; and

WHEREAS, Title XIX makes provision for a state agency to be designated to establish and maintain standards for institutions in which recipients of Medical Assistance may receive care or services and permits certain functions and services to be performed under such Title for the "single State agency" by other state or local agencies; and

WHEREAS, Health is the State agency which licenses health institutions, health maintenance organizations and agencies, the primary health service agency, and the agency designed to determine whether providers under Title XVIII of the Social Security Act meet the standards for participation in such program; and

WHEREAS, Chapter 474 of the Laws of 1996 amended Title 11, by designating Health as the "single State agency" having overall responsibility for the Medical Assistance program under Title XIX of the Social Security Act and Title 11 of Article 5 of the Social Services Law; for maintaining the "State plan" for Medical Assistance and submitting amendments thereto to HCFA; and for taking such steps, not inconsistent with law, as may be necessary to obtain and retain approval of such plan by HCFA; and

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WHEREAS, Title 11, as amended, also designates Health as the agency responsible for establishing and maintaining standards for hospital and related services and non-institutional care, reviewing and approving local social services medical plans, establishing a uniform system of reports relating to quality of medical care, reviewing the quality and availability of medical care and services furnished under local social services medical plans, and providing consultative services to providers of care under the plan; and

WHEREAS, Title 11, as amended, designates Social Services as the agency responsible for determining the eligibility for Medical Assistance of applicants therefor, and for auditing payments to providers of care, services and supplies under the Medical Assistance program; and

WHEREAS, Health and Social Services, pursuant to Title 11, as amended, are authorized to enter into such cooperative arrangements as shall be necessary to assure that the purposes and objectives of the Medical Assistance program are effectively accomplished; and

WHEREAS, the Commissioner of Health has the authority, pursuant to Title 11, as amended, to delegate responsibility under Title 11 to other state departments and agencies and to enter into memoranda of understanding as may be necessary to carry out the provisions of Title 11; and

WHEREAS, Health and Social Services have been cooperating in carrying out the directives of the Legislature in implementing the Federal requirements under Title XIX and in defining the respective functions and responsibilities of Social Services and Health under Title 11, as amended;

NOW, THEREFORE, in order to implement the Medical Assistance Program and the Federal requirements applicable thereto, and to define the respective functions and responsibilities of Social Services and Health under such program, to improve access to primary care for all recipients, to assure the delivery of high quality care, to provide comprehensive care for the health needs of all recipients and to improve the cost effectiveness of the Medical Assistance program, Social Services and Health agree as follows:

#### I. FEDERAL RELATIONS

- A. Health shall be responsible for submitting amendments of the "State plan" to HCFA necessary to implement the Medical Assistance program and for conducting negotiations with respect thereto and appealing denials thereof, in consultation with and with the participation of Social Services, as may be necessary.
- B. Health shall be responsible for submitting Medical Assistance-related demonstration and waiver applications to the federal Department of Health and Human Services (HHS) and/or HCFA. However, Health shall consult with Social Services in the development and revision of any such applications that may affect Social Services' responsibilities under the Social Services Law or this Agreement. Social Services shall assist Health in developing, revising and securing approval of any applications initiated by Health where such applications affect Social Services' responsibilities under the Social Services Law or this Agreement.

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- C. Health shall submit a summary of this Agreement to HCFA in accordance with HCFA requirements.
- D. In the event of a deferral or disallowance of federal Medical Assistance funds, associated with the activities of Health or any other State agency, the defense against said Federal action shall be the responsibility of Health. However, Health shall consult with Social Services, and such other State agencies as may be necessary or appropriate, in the development and implementation of such defense and with regard to any appeal, settlement or discontinuance of appeal of any deferral or disallowance related to Title XIX.

## II. MEDICAL ASSISTANCE ELIGIBILITY

- A1. Health shall be responsible for establishing and revising the standards and policies relating to persons' eligibility for Medical Assistance and for requiring adherence to the standards and policies relating to persons' eligibility for Medical Assistance by the social services districts of the State.
- A2. Social Services, as the single state agency under Title IV-A of the federal Social Security Act, shall, through the social services districts, be responsible for determining the eligibility of persons for Medical Assistance. Health shall be responsible for determining eligibility for Medical Assistance for residents of the Oxford Home and for individuals who are the fiscal responsibility of the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities.
- A3. Social Services may involve other State agencies in the eligibility determination process through cooperative agreements with the approval of Health.
- B1. Social Services shall have responsibility for maintenance, operation and future systems development of the Welfare Management System (WMS) and associated subsystems. This responsibility includes notification to, and coordination with, Health for all changes to this system. Reasonable accommodation will be afforded to Health to allow development of systems initiatives in consultation with Social Services to support the Medical Assistance Program.
- B2. Health shall have responsibility for maintenance, operation and future systems development of the Electronic Medicaid Eligibility Verification System (EMEVS). This responsibility includes coordination with Social Services for all systems changes. Reasonable accommodation will be provided to Social Services to allow development of systems initiatives to support operation and development of Social Services' programs.
- B3. Health shall have responsibility for maintenance, operation and future systems development of the Medicaid Management Information System (MMIS) and associated systems as defined by the federal General Systems Design (GSD). Social Services shall retain

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responsibility for the Provider Surveillance and Utilization Review System (SURS). Health shall be responsible for notification to and coordination with Social Services of any systems changes to MMIS. Social Services will consult with Health on any Provider SURS initiatives. Reasonable accommodations will be provided to Social Services to support operation and development of Social Services' programs.

- C1. Health shall maintain a system of Fair Hearings in accordance with federal requirements to hear the appeals of applicants for and recipients of Medical Assistance who are adversely affected by the actions of Health or social services districts.
- C2. Under such Fair Hearing system, social services agencies, including local social services districts, shall continue to be responsible for issuing notices of agency action with respect to matters affecting recipient eligibility. Social Services shall continue to receive requests for fair hearings, shall conduct administrative hearings and shall recommend appropriate actions with respect thereto to Health which shall issue the final administrative decisions thereon. Health shall designate appropriate staff of Social Services to issue final administrative decisions on behalf of Health, and to review issued fair hearing decisions for the purpose of correcting any error found in such decisions, including the reopening of a previously closed fair hearing record for purposes of completing such record.

### III. MEDICAL STANDARDS AND PROGRAM OVERSIGHT

- A. Health shall be responsible for establishing and maintaining, in conformance with any standards established by HHS, health standards for medical providers, as may be licensed by the State of New York, from which recipients of Medical Assistance may receive medical care or health-related services.
- B. Health and Social Services shall share the responsibility for requiring adherence by providers of medical care and health services to the regulations promulgated by Health concerning the standards of medical care and health-related services, as reflected below.
- C. Health shall, pursuant to the Public Health Law, certify managed care plans and, in consultation with the responsible special needs agency, special needs plans, for participation in the Medical Assistance program.
- D. Health shall periodically review the utilization, appropriateness, availability and quality of medical care and services furnished to recipients of Medical Assistance under the program and shall make such reports as required by law of the findings together with any recommendations in accordance with State law, the federal Social Security Act and regulations promulgated thereunder.
- E. Health shall be responsible for the administration of the Drug Utilization Review Program. Health and Social Services shall share

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the responsibility for conducting medical and drug review activity to control inappropriate utilization identified in conformance with established regulations and policies and commonly accepted medical practice.

- F1. Social Services shall be responsible for conducting audits of managed care providers and other providers of care, services and supplies enrolled in the Medical Assistance program including the responsibility for on-going fraud and abuse monitoring, investigation and referral. In this regard, Social Services shall consult with Health to ensure that such audits are conducted in accordance with Medical Assistance policy as established by Health. Social Services shall maintain a system to review and audit provider performance under the program, to recover inappropriate payments to providers and to assess provider sanctions for program violations, shall maintain a system of provider hearings to review contested audit findings, recoveries, penalties and provider sanctions, shall maintain a system for withholding payments to providers, and shall maintain a system for the final recovery of overpayments and penalties and for sanctioning and excluding enrolled providers for program violations.
- F2. Social Services audit responsibility shall include but not be limited to fiscal audits of providers (including billing audits and audits of rates conducted under Section 368-c of the Social Services Law), audits relating to provider unacceptable practices, other audits which relate to the ability of a provider to continue to participate in the Medical Assistance Program and activities related to Medical Assistance recipient fraud. Such responsibility shall also include the administration of contracts related to Social Services audit and revenue maximization responsibilities.
- G. Social Services shall continue to be responsible for the audit and review of claims paid under the Medical Assistance Program to individuals who are not enrolled as providers.
- H. Social Services and Health shall have joint responsibility for the pre-payment review of claims submitted by providers for payment under the Medical Assistance Program. Such joint responsibility shall include the effectuation of edits on claims for payments pending resolution of the review in conformance with policies and standards of Health. Reasonable accomodation will be provided to Social Services to allow development of systems to support any such initiatives.
- I. Social Services, as part of its audit and fraud control responsibility, shall be responsible for Medical Assistance third party operations and recoveries. Health shall be responsible for third party policy as it relates to Medical Assistance eligibility. Each agency shall consult and coordinate with the other to ensure an effective third party recovery program.

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## IV. PROGRAM MANAGEMENT AND ADMINISTRATION

- A. Health shall be responsible for the supervision of the administration, management and overall operation of the Medical Assistance Program.
- B. Health shall be responsible for the establishment of the Medical Assistance delivery network; and recruitment, selection and procurement of providers and managed care plans; provided, however, nothing herein shall prohibit social services districts or groups of districts from procuring providers or managed care plans with the approval of Health.
- C. Social Services shall be responsible for conducting management assessment reviews and audits, and for performing Medical Assistance quality control reviews of social services districts.
- D. Social Services shall assure that medical care and health-related services, under Medical Assistance, be made available in all social services districts to the extent required by law and the regulations of Health and, where Health has determined that sufficient capacity exists in the managed care entities serving a district, assure that recipients receive such care under the managed care program in accordance with the regulations of Health.
- E. Health shall be responsible for enrolling medical care providers into the Medical Assistance program, instructing them with respect to participation requirements and assuring payment and shall provide for agreements with providers of services under the State plan, in accordance with applicable Federal requirements. Nothing herein shall preclude Health from delegating to Social Services the responsibility for making an initial determination with respect to provider enrollment applications for those groups or types of providers that Health deems appropriate and for instructing such providers with respect to participation requirements.
- F. Either Social Services or Health may terminate a provider's enrollment under the Medical Assistance program upon advance notice to the provider. Any such termination instituted by Social Services shall be upon advance written notice to and approval by Health. Health and Social Services shall establish a mechanism to provide for the notification to each other of any such terminations.
- G. Health, in consultation with Social Services, shall be responsible for the design, development and operation, either directly or by contract, of the information systems which are necessary to support provider enrollment and payment functions under the Medical Assistance program. Provided, however, that, prior to entering into any contracts with fiscal agents, or extending the current contract, Health shall ensure that such contracts make adequate provision for assuring proper integration of Social Services' responsibilities, including Medical Assistance eligibility determination, fiscal audits, fraud and abuse under this Agreement and information systems shall at a minimum be

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accessible by Social Services and shall permit Social Services, upon notification to Health, to initiate withholding of payments, recoveries, terminations of enrollment and sanctions, as they relate to Medicaid providers. Social Services and Health shall develop procedures for the input and retrieval of information by Social Services related to such system and for the development of reports required by Social Services in its audit and fraud control responsibilities. Social Services shall have the right to disseminate information obtained from such systems in the course of its responsibilities and consistent with federal and state confidentiality requirements.

- H. Social Services shall be responsible for provider fraud control mechanisms including but not limited to "post and clear" and "card swipe". Social Services shall consult with Health during the development of any new initiatives.
- I. Social Services shall be responsible for the development, implementation and monitoring of the Social Services Medical Assistance audit plan. Social Services shall consult with Health in the development of such plan and shall periodically advise Health of the status of all initiatives contained in the plan. All recoveries received by Social Services shall be processed and deposited in a manner to be developed by Social Services and Health.
- J. Social Services shall continue to be responsible for medical support enforcement activities pursuant to the provisions of Title IV-D of the Social Security Act.
- K. Social Services shall continue to be responsible for interaction with local services districts regarding local district Medical Assistance fiscal activities. Such responsibility shall include the processing of administrative and program claims, interception of funds for local district escrow accounts, recoupment of intergovernmental transfer revenue, issuance of disproportionate share payments, and maintenance of local district cost allocation plans.
- L. Health shall be responsible for interaction with other State agencies regarding Medical Assistance claiming and the processing of reimbursement requests. Health shall be responsible for the filing of the Medical Assistance Quarterly Expenditure Report.
- M. Social Services shall be responsible for the administration of the existing training contract with the State University College at Buffalo. Health shall be responsible for all training functions under the contract which are related to Medical Assistance.
- N. Social Services shall be responsible for all Medical Assistance disability determination functions, including establishment of disability policy and, where applicable, review of social services district procedures.

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## V. RATES AND FEES

- A. Health shall establish fees, rates and payment methodologies for providers of medical care and health-related services and shall establish the range of acceptable rates of payment for managed care providers, under the Medical Assistance Program. Provided, however, that nothing herein shall be interpreted as affecting the authority of local social services districts or other state agencies to establish rates of payment where such authority existed prior to the date of this Agreement.
- B. Methodologies and levels of payment for physician case management programs, for comprehensive health services programs with special purpose certificates of authority and for special needs plans or programs shall be developed by Health in consultation with the responsible special needs agency.

## VI. REPORTS, FORMS AND PROCEDURES

- A. Through cooperative efforts, Social Services and Health shall develop mutually satisfactory forms and procedures for carrying out their respective responsibilities under Title 11 of Article 5 of the Social Services Law and this Agreement. Such forms and procedures shall include those necessary for determining eligibility for Medical Assistance and claiming Federal reimbursement.
- B. Health shall require such reports as are or may be necessary to comply with Federal requirements and Social Services shall do whatever may be necessary to assure that such requirements may be met.
- C1. Health, in consultation with Social Services, shall determine the nature and extent of the information which should be collected from providers and shall design reports required to monitor the health care provided under the Medical Assistance program. Health shall determine the nature and extent of the information which should be collected from providers for the purpose of establishing rates of payment and shall design such reports as are necessary to establish rates of payment and acceptable ranges of payment, including the collection and reporting of encounter data from managed care programs and HMOs. Social Services shall have access to any such information needed to carry out its responsibilities under this Agreement.
- C2. Social Services shall provide advice and assistance to Health in the determination of the nature and extent of information to be collected from and design of reports for social services districts affecting their program and fiscal responsibilities.
- D. In order to effectively monitor the quality and appropriateness of the care provided, to identify patterns of under-utilization or aberrant care practices, to provide information necessary for plan quality assurance and improvement activities, and to streamline multiple reporting activities, Health, in consultation with Social

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Services, shall be responsible for the design and implementation of an encounter data system sufficient to meet the needs of the State agencies and social services districts having responsibility for the implementation of the Medical Assistance program. These responsibilities shall include: identification of key clinical and utilization variables, data collection, and maintenance and training and technical assistance to providers. Social Services shall have access to all such data and information.

- E. Health shall be responsible for obtaining data relating to the quality and availability of medical care and health services furnished under the Medical Assistance program and shall have the responsibility for collection of encounter data for the managed care program. Social Services shall continue to collect and process encounter data from providers currently enrolled in the Medical Assistance program until such time as the universal encounter data set is established, new provider agreements are executed with the providers, or Health has assumed responsibility for enrolling providers into the Medical Assistance program. Social Services shall have access to all such data and information.
- F. Health shall provide encounter data and payment reports to Social Services, at such times and in such manner as may be necessary, to enable Social Services to carry out its functions and its responsibilities to supervise the social services districts under the Medical Assistance program and to carry out its functions and responsibilities with respect to fiscal audits, fraud and abuse, and provider sanctions.
- G. Until such time as Health establishes a formal process for the communication of Medical Assistance policy to social services districts, Health shall have access to existing methods within Social Services for such communications. Communications included under the terms of this paragraph include but are not limited to Administrative Directives, Local Commissioners Memoranda, and the General Information System. Health and Social Services shall cooperate in this regard such that there is no interruption in the flow of Medical Assistance communications to the social services districts. Health shall use best efforts to establish a Medical Assistance policy communications process as soon as practicable.

#### VII. GRIEVANCE PROCEEDINGS AND APPEALS - RECIPIENTS

- A. As provided for hereinabove and consistent with relevant federal and State law with respect thereto, upon designation by Health, Social Services shall make provisions for hearing appeals by applicants for, or recipients of, Medical Assistance with respect to their eligibility for Medical Assistance and any adverse agency action taken with respect thereto; holding fair hearings on such appeals when hearings are requested; recommending final decisions and determinations; issuing final administrative decisions on behalf of Health through staff designated by the Commissioner of Health; and taking such steps as may be necessary to enforce Health's final determinations and decisions.

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- B. Health, as the single state agency, shall decide and issue final administrative decisions on appeals reviewed or heard by Social Services in accordance with the requirements of the Social Services Law and federal law and regulations, as applicable. Health shall designate appropriate individuals in Social Services to issue final administrative decisions on behalf of the Commissioner of Health and to review issued fair hearing decisions for the purpose of correcting any error found in such decisions, including the reopening of a previously closed fair hearing record for purposes of completing such record. Health delegates to Social Services the responsibility for deciding and issuing those decisions in which Medicaid eligibility is dependent upon or affected by an individual's eligibility for public assistance. Health also delegates to Social Services the authority to respond on its behalf to any correspondence, contacts or inquiries relating to medical assistance hearings which are directed to Social Services, to Health, or to the Commissioner of Health.
- C. Health, consistent with its responsibility under the Public Health Law, this Agreement and the federal requirements therefor, shall assure that recipients, who are enrollees in managed care plans under the Statewide managed care program, shall have access to grievance and appeal procedures regarding services by their respective managed care plans, as specified in section 4403(1)(g) of the Public Health Law, 10 NYCRR 98.14 and the federal laws and regulations governing such procedures.

#### VIII. MONITORING AND ENFORCEMENT OF AGREEMENT

Except as otherwise specified to the contrary herein, Health, in consultation with Social Services, shall establish and implement policies and procedures reasonably necessary to monitor and evaluate the effectiveness and efficiency of the activities performed under this Agreement and the Medical Assistance program, appropriate to its responsibilities under State law and in accordance with applicable requirements of federal law and regulation.

#### IX. ADMINISTRATIVE PROCEEDINGS - PROVIDERS

- A. Consistent with its responsibilities hereunder, Social Services shall be responsible and have authority for determining the amount of any restitution or administrative penalty due from a managed care plan or other provider, resulting from receipt of overpayment, fraud, abuse, or an unacceptable practice, and other administrative penalties, including but not limited to suspension, disqualification or limitation of such provider's participation in the program. The Commissioner of Social Services, or designees, shall be delegated to perform any and all of the functions and shall have the authority for all actions described in 18 NYCRR Parts 515, 516, 517, and 518 and for the conduct of administrative proceedings to review such actions as described in 18 NYCRR Part 519 including the authority to render a final administrative decision.

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- B. Notwithstanding the foregoing provisions hereof regarding Social Services' responsibilities with respect to fraud and abuse, Health shall retain its jurisdiction with respect to licensure of hospitals, as defined under Article 28 of the Public Health Law, HMOs and home health agencies, and physicians, physician assistants and specialists' assistants.
- C. Health retains its authority regarding any provider's violation of Article 33 of the Public Health Law. This will also pertain when the provider's violations occur when providing services in the Medical Assistance program. For the purposes of effectuating penalties designed to deter violations of Article 33 of the Public Health Law, Social Services shall be responsible for monitoring compliance by Medical Assistance providers with orders issued pursuant to Public Health Law Article 33.

#### X. CIVIL PROCEEDINGS

- A. Social Services shall have authority in those proceedings involving any provider's violation of Article 33 of the Public Health Law for recovery of such sums of money obtained by a provider or other vendor as the result of fraud, abuse, or unacceptable practice in the Medical Assistance program and to perform such other acts as may be necessary to enforce other civil penalties provided for in law. Social Services shall have primary responsibility and authority for interacting with the Department of Law in the defense of those actions brought against Social Services as a result of a determination made relating to its audit functions and in any action brought seeking recovery of overpayments or penalties identified in an audit or review conducted by Social Services.
- B. Health delegates to Social Services the responsibility and authority to defend state and federal litigation involving appeals of final administrative hearing decisions issued by Social Services staff designated by Health. This delegation shall be limited to cases where the primary issue is whether the decision was based on substantial evidence, or where the fair hearing process itself is challenged, either systemically or in individual cases. Health also delegates to Social Services the authority to approve the payment of attorney's fees by Health in appropriate cases, in the course of settlement negotiations, or where directed by a court's decision.

#### XI. CRIMINAL PROSECUTION

Social Services shall be responsible and shall have the authority for the preparation of cases involving fraud, abuse or unacceptable practice in the Medical Assistance program for referral to an appropriate prosecuting agency or agencies. Nothing herein shall be construed as precluding Health from consulting with or referring matters to such prosecuting agency or agencies.

#### XII. FEDERAL ADVANCES

- A. Health will periodically obtain, in conformity with applicable Federal regulations and practices, advances against Federal funds

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provided for the conduct of the functions and activities herein prescribed and authorized under the Medical Assistance program. Such funds may be received by the State Comptroller and, upon allocation in accordance with applicable provisions of law, shall become available to Health and Social Services in anticipation of Federal reimbursement to which they may become entitled as a result of reasonable and necessary costs incurred in performing the functions authorized by this Agreement.

- B. Health will submit estimates of anticipated costs and entitlement to Federal reimbursement as a result thereof for such periods in accordance with federal requirements. Such costs shall be limited to costs allowable for the functions and activities herein provided in accordance with records maintained by Health or submitted by Social Services, including, but not limited to, the names of employees, salaries paid, hours of performance and specification of such activities; provided, however, that where Health or Social Services utilize services or materials in the execution of this Agreement for purposes which include purposes other than those encompassed by Title XIX, the cost of those services or materials shall be claimed for federal financial participation in accordance with one or more cost allocation plans which meet the requirements of OMB Circular A-87 and 45 CFR 95.507.
- C. At such intervals as Health may reasonably require, Social Services will submit a report of its actual expenses in executing the functions and activities authorized under such Title XIX. Health will determine whether such expenditures were necessary for the performance of the functions authorized by this Agreement and will compare such expenditures and Social Services' entitlement to Federal funds, as a result thereof, to the advances received from Federal funds for the period. If Health's examination of such expenditures determines that any such expenditure was not necessary to the purposes of this Agreement, Health shall inform Social Services of such determination. Social Services will be given a reasonable length of time, but not less than thirty (30) days, to justify such expenditures. If Health thereafter finds that such expenses are not necessary to the performance of such purposes, Social Services' entitlement to Federal reimbursement shall be reduced by an amount so determined and subsequent Federal advances adjusted, by increase or reduction, to compensate for such expense and for any difference between entitlements reported for the prior period and the advance for that period.

### XIII. STAFFING

- A. As required by Civil Service Law and regulations, Social Services shall identify and assign to Health such staff, who are substantially engaged in functions related to the supervision of the State's Medical Assistance program, in such numbers as may be required to perform the functions assigned to Health under this Agreement. Staff so identified and assigned shall have relevant background, knowledge, skills and abilities necessary to the performance of such functions and must be acceptable to Health. Staff identified for assignment to Health will have the legally

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 Supervises TN New Effective Date OCT 01 1996

prescribed time frames from their notification of assignment to Health to protest such assignment. Health and Social Services shall have joint responsibility for determining the disposition of any such protest.

- B. On an ongoing basis, Social Services and Health shall determine the nature and extent of the staffing needs of each agency with respect to their roles and responsibilities under this Agreement and may develop such staff deployment and redeployment plans to provide for the permanent transfer of such staff as is deemed necessary to effectively perform their respective functions hereunder. Social Services and Health shall effect the permanent reassignment and redeployment of such staff as is deemed necessary to effectively perform their respective functions hereunder in accordance with applicable provisions of the Civil Services Law and related statutes.

XIV. MISCELLANEOUS

- A. Social Services and Health shall observe and require the observance of the applicable requirements relating to confidentiality of records and information and each agrees not to allow examination of records or to disclose information, except as may be necessary for the purpose of obtaining medical care and health services, assuring the propriety of such care and service, or the proper discharge of responsibilities relating thereto, and except as provided by applicable State and Federal laws and regulations.
- B. Social Services and Health shall observe and require the observance of the requirements of Title V of the Civil Rights Act of 1964.

XV. TERMS OF AGREEMENT

- A. This Agreement shall be effective only to the extent that it is found by HCFA to be permitted under applicable Federal law and to the extent that Federal aid is not impaired thereby.
- B. Social Services and Health shall designate specific personnel in each State agency responsible for continuous liaison activities, including regular meetings and summaries thereof provided to the signatories hereto, to evaluate policies that affect the Medical Assistance program.
- C. This Agreement shall run from the date hereof for a period of one year, at which time Health and Social Services shall review the Agreement for any needed changes and jointly plan to incorporate any such changes in the Agreement. If no changes are deemed appropriate, this Agreement shall automatically be renewed upon the same terms for additional periods of one year unless amended in writing by mutual agreement of the parties.
- D. To the extent permitted by law, either party may terminate this Agreement on 30 days advance notice in writing to the other party. If terminated, any funds paid to Health under the provisions of this Agreement which have not been expended or encumbered in

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accordance with the provisions of this Agreement prior to the date on which the Agreement was terminated and property purchased with funds paid to Health under the provisions of this Agreement, shall be accounted for in accordance with standards established by Social Services governing disposition of such property and funds.

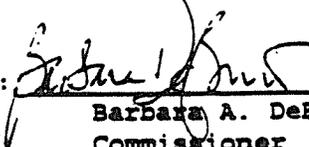
E. This Agreement may be amended from time to time; however, no such agreement shall be effective unless signed by the Commissioners of Health and Social Services and shall be effective only to the extent set forth in paragraph A. above.

F. The Memorandum of Understanding entered into between the parties on August 4, 1987 is hereby terminated. Provided, however, such August 4, 1987 Memorandum shall guide the parties in resolving any unforeseen problems or issues arising hereunder and in resolving any ambiguities herein.

Dated at  
Albany, New York

9/30, 1996

NEW YORK STATE DEPARTMENT  
OF HEALTH

By:   
Barbara A. DeBuono  
Commissioner

NEW YORK STATE DEPARTMENT  
OF SOCIAL SERVICES

1/1 3, 1996

By:   
Brian D. Wing  
Acting Commissioner

TN 96-45 Approval Date JAN 31 1997  
Supersedes TN New Effective Date OCT 01 1998

State of New York

Summary of Agreement between New York State Department of Social Services (DSS) and New York State Office of Mental Health (OMH) (within the New York State Department of Mental Hygiene) dated September 29, 1982 and superceding all previous Agreements. Such agreement serves also as a Provider Agreement between the two agencies.

This Agreement makes provision of coverage under Medical Assistance for the following:

- o persons under care in a general acute care hospital while on release from an OMH facility
- o persons placed in family care on conditional release from an OMH facility
- o persons age 65 or older who are in an OMH facility
- o persons age 21 or younger who are in an OMH facility or a private not-for-profit facility duly certified for such by the OMH
- o persons found in a psychiatric section of a general acute care hospital duly certified by the OMH and the New York State Department of Health

New York State Department of Social Services is responsible for:

1. Furnishing public and/or medical assistance.
2. Establishing standards of eligibility.
3. Determining eligibility within appropriate time frames.
4. Authorizing public and/or medical assistance.
5. Making provision for appeals and fair hearings.
6. Developing, in cooperation with the OMH, a system of reports to be made periodically to DSS relating to necessary data in connection with medical assistance provided.
7. Observing and requiring confidentiality of all records pertaining to client care.
8. Issuing policy, rules and regulations pertaining to the Medicaid program and for interpretation of the State Plan as the Single State Agency.
9. Forwarding to OMH, in a timely fashion, any communications relating to OMH's performance or responsibilities as an authorized medical provider.
10. In cooperation with the OMH jointly plan for developing alternate methods of care for the mentally ill.
11. Periodically transferring Federal Funds to OMH under an advance system.

Approved Date JUL. 17 1985 Effective Date APR. 1 1985

ny-85-11  
superceded  
14-74-2

## State of New York

The New York State Office Mental Health is responsible for:

1. Establishing mental health standards for inpatient and outpatient services furnished by public and private facilities.
2. Requiring adherence by State institutions to such standards.
3. Making application to Social Services for public and/or medical assistance on behalf of patients.
4. The marshalling, exploration and verification of all income and resources of patients.
5. Prompt application to Social Security Administration for appointment of Representative Payee as indicated.
6. Notify Social Services within 30 days of any change affecting eligibility.
7. Maintaining records necessary to fully disclose the nature, amount and duration of services reimbursed by medical assistance.
8. Assuring that each OMH facility has in effect a utilization review plan including medical care evaluations as required by applicable statute and/or regulation.
9. Furnishing DSS with notices of adverse utilization review determinations made on behalf of their facility's patients.
10. Billing DSS only for actual and necessary care rendered.
11. OMH agrees to comply with federally mandated disclosure requirements.
12. Conducting periodic medical reviews either directly or through contract of medicaid clients need for or continued care in public or private hospital facilities under OMH's licensure.
13. Participation in fair hearings as advisors or expert witnesses.

Approved Date JUL. 17 1985 Effective Date APR. 1 1985

NY-85-11  
supersedes  
NY-74-2

Summary of Agreement between New York State Department of Social Services (DSS) and the New York State Office of Mental Retardation and Developmental Disabilities (within the NYS Department of Mental Hygiene) (OMR/DD) dated April 19, 1993 and April 30, 1993.

The New York State Department of Social Services shall be responsible for:

1. Establishing or revising standards, policies and procedures for determining eligibility for Medical Assistance.
2. Maintaining, through training programs and prompt updating of procedural changes, ongoing responsibility for the eligibility determination process.
3. Determining eligibility within 30 days of receipt of all information necessary to complete such determination from OMR/DD.
4. Maintaining free access to all eligibility documentation gathered by OMR/DD and periodically auditing that documentation to assure the accuracy and completeness thereof, as the basis for eligibility determinations made by DSS; complete system eligibility information shall be maintained by DSS subject to system purges/limitation.
5. Providing fair hearings in accordance with applicable DSS and HHS regulations for Medical Assistance applicants or recipients served by OMR/DD operated or licensed facilities.
6. Submitting amendments to "State Plan" and submitting this agreement as required by federal rules and serving as liaison with respect to all State Plan amendments, issues of compliance, or any other federal inquiry.
7. Entering into written provider agreements for the provision of Medical Assistance to eligible individuals only with providers certified by the Department of Health as meeting applicable standards for the provision of such services under federal and State law, which agreements will be in the form established and approved by DSS and shall comply with federal survey and certification requirements; DSS shall have the right to refuse to enter into such agreements, cancel, or suspend such agreements, with any provider should it determine that such provider is not in compliance with such requirements or that the provider has failed to comply with any of the terms thereof.
8. Providing a printout of annual redetermination cases at least 90 days prior to the expiration of the current authorization period.

TN 93-22 Approval Date SEP 13 1993  
Supersedes TN 85-11 Effective Date APR 30 1993

The New York State Office of Mental Retardation and Developmental Disabilities shall be responsible for:

1. Making application for Medical Assistance benefits on behalf of potentially eligible clients, and on behalf of those on release from an OMR/DD facility to receive care in a medical facility, application to be made no later than 30 days after receipt of all information needed to support an eligibility determination by DSS.
2. Marshalling, exploring, developing and verifying all income, resources, third-party benefits, and other eligibility information in order that DSS may accurately determine eligibility.
3. Notifying Social Services immediately upon receiving knowledge of any change that affects eligibility for Medical Assistance.
4. Timely notifying Social Services of any newly certified providers, of those providers which are decertified, and of any changes in addresses, ownership program capacity or otherwise.
5. On request, participating in Fair Hearings as advisors and witnesses.
6. Certifying to DSS that all facilities operated or licensed by OMR/DD for which reimbursement is claimed meet applicable federal standards.
7. Supplying Social Services in a timely manner with any documentation requested hereunder.
8. Conducting utilization review activities, required for all medical care and services including:
  - a. development of forms, criteria, training and technical assistance;
   
approval of UR plans;
   
placement planning, level of care determinations; and
   
assuring that the general federal requirements are met (42 CFR 456.1 - 456.23);
  - b. In the case of ICF/DD's assuring that, in addition to meeting general federal criteria, they meet requirements of 42 CFR 456.350 - 456.438 as to -
    - (1) Certificate of need,
    - (2) Evaluation and pre-admission reviews,
    - (3) Plan of care,
    - (4) Written UR review plans,
    - (5) Continued stay review,
    - (6) Description of UR review function.

TN 93-22 Approval Date SEP 13 1993

Supersedes TN 85-11 Effective Date APR 30 1993

9. Assuring the Independent Professional Reviews (IPR's) are conducted on a regular basis; consulting with Social Services as to their conduct and the contracting therefor; and initiating corrective action for problems identified thereby.
10. Surveying all facilities and programs under its jurisdiction and periodically evaluating all services for the developmentally disabled delivered under the auspices of these facilities and programs, as pertains to Medical Assistance.
11. Establishing regulations and procedures for all facilities and services under its jurisdiction and consulting Social Services regarding same prior to promulgation or implementation thereof, as pertains to Medical Assistance.
12. To ensure high quality provision of services, providing consultative services through its regional offices (District/Borough Developmental Services Office) to all Medical Assistance services administered by OMRDD.
13. Where appropriate, OMR/DD shall seek recoveries of Medical Assistance and credit such recoveries to DSS.
14. Sharing appropriate training materials with DSS when those materials pertain to the delivery of Medicaid services, so that DSS input can be made.
15. Consistent with the delegation of authority accepted by this agreement, where applicable, OMR/DD will establish reimbursement rates, fees and schedules for residential and non-residential care services in consultation with DSS and with the approval of the State Division of the Budget.

TN 93-22 Approval Date SEP 13 1993  
Supersedes TN 89-43 Effective Date APR 30 1993

Summary of Agreement between the New York State Department of Social Services (DSS) and the New York State Division of Alcoholism and Alcohol Abuse (within the Department of Mental Hygiene) (DAAA) being dated December 30, 1981.

This agreement relates to the provision of Medicaid benefits to such persons who are admitted for either inpatient or outpatient care and services in facilities that fall under jurisdiction of the Division of Alcoholism and Alcoholism Abuse.

The New York State Department of Social Services shall be responsible for:

1. Establishing standards and criteria of eligibility for Medical Assistance.
2. Authorizing public and/or Medical Assistance.
3. Furnishing public and/or Medical Assistance.
4. Making provisions for appeals and Fair Hearings.
5. Observing and requiring the confidentiality of records according to applicable statutes and regulations.
6. Administering the Medicaid program and verifying the quality and appropriateness of care rendered and reimbursed under this agreement.
7. Reimbursing all allowable direct and indirect expenditures incurred.

The Division of Alcoholism and Alcohol Abuse either directly or through contract with the Office of Mental Health is responsible for:

1. Developing standards and policy governing the provision of medical care and/or rehabilitation relating to alcoholism.
2. Requiring adherence to such standard in state operated or voluntary operated facilities and settings.
3. Making application to Social Services for public or medical assistance on behalf of its patients.
4. The marshalling, exploring and verification of all income and resources of patients.
5. Maintaining records and reports that disclose the amount and duration of care supplied under the Medicaid program including indirect service costs under the Agreement.
6. Conducting annual periodic medical reviews and quality assurance reviews.
7. Billing Social Services only for actual allowable days of care as services provided under Medicaid.
8. Maintaining with Social Services an accurate and updated list of all providers eligible under Title XIX.
9. Participating in fair hearings as advisor or expert witness.

Amended Date JUL 17 1985 Effective Date 12-30-81

*NY-85-11*  
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Attachment 4.16-A

A. Summary of the Agreement between the New York State Department of Social Services on behalf of the Division of Medical Assistance (DMA) and the New York State Department of Health on behalf of the Center for Community Health (CCH) dated June 12, 1989.

The New York State Department of Social Services shall:

1. Provide local social services with CCH supplied lists and descriptions of current MCH primary and preventive health care programs and programs for CSN (including Maternal and Child Health Block Grant funded programs) operating in the local social services district.
2. Disseminate CCH supplied brochures describing program services and eligibility requirements to local social services districts.
3. Ensure that the local social services districts refer individuals who may be eligible for medical, nutritional or dental services to the local MCH primary and preventive health care programs.
4. Authorize payment of Medical Assistance funds for care, services and supplies covered under the Medical Assistance Program and provided to Medicaid recipients by MMIS enrolled MCH primary and preventive health care and CSN providers.

TN 89-43 Approval Date MAR 12 1992  
Supencodes TN 85-11 Effective Date JUL 1 1989

5. Coordinate and defend the deferral and disallowance of Medicaid funds associated with the activities of DMA and CCH.
6. Conduct periodic evaluations of local social services districts to ensure that protocols established in accordance with this Agreement are implemented effectively.

The New York State Department of Health shall:

1. Disseminate written information describing the Child/Teen Health Plan (C/THP) and other Medical Assistance services and eligibility requirements to local MCH primary and preventive health care programs and programs for CSN.
2. Provide local MCH primary and preventive health care programs and programs for CSN with DMA supplied brochures describing C/THP and other Medical Assistance services
3. Ensure procedures are in place for referral of all persons who may be eligible for Medicaid benefits but whose eligibility has not been determined.
4. Ensure that MCH primary and preventive health care program providers receiving Medicaid reimbursement for primary ambulatory care services covered by the C/THP program and rendered to C/THP eligibles participate and report

TN 89-43 Approval Date MAR 13 1992  
Supersedes TN New Effective Date JUL 1 1989

such services as Child/Teen Health Plan examinations.

5. Be responsible within limits of the appropriations for payment for care, services, and supplies provided to MCH primary and preventive health care programs and programs for CSN participants not fully eligible for Medical Assistance as found in 18 NYCRR Part 360.
6. Conduct periodic evaluations of local MCH primary and preventive health care programs and programs for CSN to ensure that the quality of care is accordance with DOH standards.

Jointly the New York State Department of Social Services and the New York State Department of Health shall:

1. Make training programs available to local health care program providers and local social services districts to enable them to coordinate efforts of eligibility determination and increasing access to services.
2. Provide to each other, upon request, available data on clients participating in MCH primary and preventive health care programs and programs for CSN and the Medical Assistance Program.

TN 89-43 Approval Date MAR 13 1992

Supersedes TN New Effective Date JUL 1 1989

3. Explore and study the feasibility of conducting special outreach, referral and tracking efforts directed at Medical Assistance eligibles who are either unserved or underserved and may be eligible for MCH primary and preventive health care programs or programs for CSN.
4. Meet annually, and more often as needed, and be responsible for the coordination of planning for effective service delivery, and consideration of new initiatives, and the discussion of any issues or resolution of any problem which may arise under the terms of this Agreement.
5. Ensure that local social services districts and local MCH primary and preventive health care programs and programs for CSN participate as appropriate in these discussions and are informed of any policy changes that occur in accordance with the terms of this Agreement.

Terms of this Agreement:

1. No amendment of the terms of this Agreement shall be valid unless reduced to writing and signed by the necessary parties.

TN 89-43 Approval Date MAR 13 1992

Supersedes TN New Effective Date JUL 1 1989

2. This Agreement may be terminated by any of the parties hereto upon 30 days written notice to the other party.
  
3. This Agreement shall be for a period of two years beginning on the day last appearing and shall automatically be renewed for successive periods of two years, unless there is written notice to the other party of its intention not to renew the Agreement at least 30 days before the end of the current period.

TN 89-43 Approval Date MAR 1 8 1992  
Supersedes TN New Effective Date JUL 1 1989

Summary of a revised Agreement, dated January 14, 1983 between the New York State Department of Social Services and the Office of Vocational Rehabilitation (OVR) within the New York State Department of Education relating to medical assistance benefits.

The agreement relates to the joint development of services for the non-blind handicapped and defines the reimbursement responsibilities for each agency when mutually serving the same client.

New York State Department of Social Services is responsible for:

1. Authorizing public and/or medical assistance.
2. Referring applicants/recipients to OVR when rehabilitation needs are indicated.
3. Being payor in the first instance for those prescribed services which part of a rehabilitation plan of care, are covered services by Title XIX.
4. Providing funds for care and maintainance to eligible persons served by both agencies.

The Office of Vocational Rehabilitation is responsible for:

1. The provision of vocational rehabilitation services to the non-blind physically and mentally handicapped persons.
2. To develop, restore and/or improve the work capacities of the vocationally handicapped.
3. OVR shall refer to DSS for public assistance, any OVR applicant/client who appears in need of such social services.

OVR and DSS shall jointly be responsible for:

1. Developing financial and service plans for any case receiving both public assistance and rehabilitation services.
2. Establishing a regular visitation schedule in order to maximize resources for mutually shared clients.
3. Sharing of data and information that would change the eligibility of the mutually shared client for continuing prescribed care or services.
4. Designing training for agency staff and linkage routes for effectiveness and efficiency.
5. Observing client confidentiality rules.

Approval Date JUL. 17 1985 Effective Date \_\_\_\_\_

NY-85-11  
supersedes  
NY-74-2

Summary of Cooperative Agreement between the New York State Department of Social Services and the New York State Superintendent of Insurance, dated January 14, 1985.

There is a joint responsibility of the above parties, including local Social Services districts that upon request to any other third party insurers for necessary information, that such request is only made to determine whether any insurance or other benefits have been or should have been claimed and paid with respect to items of medical care and services received by a particular individual for which medical assistance coverage would otherwise be available.

Approval Date JUL. 17 1985 Effective Date APR. 1 1985 NY-85-11  
supercedes  
NY-74-2

Summary of Agreement between New York State Department of Social Services (DSS) and the New York State Education Department (SED) dated October 25, 1993 and October 12, 1991.

The New York State Department of Social Services shall be responsible for:

- 1) Establishing or revising standards, policies and procedures for administration of "School Supportive Health Services" (SSHS) in the Medical Assistance program.
- 2) Assuring the SED will be informed of all information required to meet any current and new mandates of the Medical Assistance program as they pertain to School Supportive Health Services Program (SSHSP).
- 3) Initiating amendments to the "State Plan" and submitting these to federal Department of Health and Human Services (HHS); and serving as liaison with respect to all State Plan Amendments, issues of compliance, or any other federal inquiry.
- 4) Entering into written provider agreements for the provision of Medical Assistance to eligible individuals only with providers meeting applicable standards for the provision of such services under federal and State law, which agreements will be in the form established and approved by DSS and shall comply with applicable federal requirements. DSS shall have the right to refuse to enter into such agreements with any provider should it determine that such provider is not in compliance with such requirements or that the provider has failed to comply with any of the terms thereof.
- 5) Reviewing and approving curriculum related to SED's training of school districts for the SSHSP.

The State Education Department shall be responsible for:

- 1) Reviewing of school districts' eligibility to become SSHS.
- 2) Providing school districts with training and information on participation in the Medical Assistance Program as SSHSP providers.
- 3) Establishing a system to assure that the school districts bill the Medical Assistance Program only for those types of services which are Medicaid reimbursable.
- 4) Monitoring the school districts' provision of SSHS to children with or suspected of having disabilities in accordance with Part 200 of the Regulations of the New York State Commissioner of Education and Article 89 of State Education Law.

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Supersedes TN New Effective Date MAY 21 1992

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- 5) Obtaining written assurances from the school districts of their compliance with applicable rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Social Services as set forth in Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other publications of the Department, including Medicaid Management Information System Provider Manuals and other official bulletins of the Department and assuring that the local school districts understand and agree that they shall be subject and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting a school district's past, present and future status in the Medicaid program and/or imposing any duly considered sanction or penalty.
- 6) Monitoring school districts' compliance with:
  - o documentation requirements of SSHS;
  - o the obligation to provide SSHS by appropriately licensed or certified staff who meet Medicaid standards; and
  - o other third party insurance requirements.
- 7) Obtaining assurances from each school district to supply DSS with any documentation requested hereunder in a timely manner.
- 8) Obtaining assurances from each school district that it will not seek Medicaid reimbursement for any service paid for with other federal funds.
- 9) Assuring that Federal Medicaid funds are properly matched with State funds.
- 10) Obtaining assurances from each school district that they will not bill Medicaid for services covered by other third party reimbursement.

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 Supersedes TN New Effective Date MAY 21 1992

Summary Of Agreement between New York State Department of Social Services (DSS), State Education Department (SED), and the Office of Mental Retardation and Developmental Disabilities (OMRDD).

1. State Education Department will be responsible for:
  - a. SED will reimburse school districts for the cost of education and related services provided to children who reside in an ICF/DD and attend a public school, a Board Cooperative Education Services ("BOCES") program, or a SED approved school not operated by an ICF/DD.
  - b. SED will provide OMRDD with cost data for education and related services for each child residing in an ICF/DD who attend public schools, BOCES, or SED approved school, or SED approved schools operated by ICFs/DDs. Such cost data will be provided on a mutually agreeable time schedule in a format prescribed by OMRDD. SED understands that OMRDD will use this data to develop ICF/DD reimbursement rates which include these and other costs allowable under the Medicaid program.
  - c. SED agrees to be responsible for and to pay to DSS any disallowance taken pursuant to federal and/or state law. SED will recoup such disallowance by allowing OMRDD to adjust the appropriate ICF/DD reimbursement rate to account for such disallowance.
  - d. SED will continue to monitor the education programs provided to children residing in ICFs/DD.
  - e. SED will direct school districts that they cannot access Medicaid reimbursement from the School Supportive Health Services Program ("SSHP") for any child residing in the ICF/DD. SED and DSS will implement procedures to assure that there will be no double billing or double payment for educational and related services provided by school districts to children residing in ICFs/DD.
  - f. SED will transfer to DSS the amount of non-federal share of any and all funds associated with claims for Medicaid from non-state operated ICF/DDs made pursuant to this agreement. The amount of the transfer to DSS will be based upon a contribution by SED of 50% of the estimated cost for education and related services which are part of the ICF/DD rate calculation as determined pursuant to paragraph b above, and reconciled to actual costs based upon adjudicated claims as determined by DSS.
  - g. SED will review for form the contracts between the ICFs/DD and the school districts for education and related services and ensure that OMRDD receives signed copies of all such contracts.

TN 96 - 42Approval Date OCT 28 1998Supersedes TN New Effective Date JUL 1 1998

2. Office of Mental Retardation and Developmental Disabilities will be responsible for:
  - a. After payment is made by DSS through MMIS for all education and related services, OMRDD will recoup from participating non-state operated ICFs/DD the cost of such services provided to children residing in an ICF/DD and receiving education and related services in a public school, BOCES or a SED approved private school not operated by the ICF/DD and any other education costs incurred by a school district responsible for the education of the child from the reimbursement rate (calculated in accordance with paragraph (1)(b) above) of the ICF/DD and transfer such funds to SED on a mutually agreeable schedule.
  - b. Upon payment by DSS, OMRDD will transfer to SED the Federal share for any and all Medicaid payments for education and related services provided to children who reside in state operated ICFs/DD and receive educational and related services in public schools, BOCES, or an SED approved private school not operated by a state operated ICF.
  - c. OMRDD will not be responsible for the state share of any Medicaid payment nor be responsible for payment of any Medicaid disallowance, however, in the event of any disallowance, OMRDD agrees to recoup the amount of any disallowance from the ICFs/DD incurring such disallowance by an adjustment to the reimbursement rate calculated in accordance with paragraph 1(b) and in accordance with paragraph 1(c).
  - D. OMRDD will continue to monitor IDF/DD program plans to assure compliance with applicable state and federal ICF/DD requirements.
3. Department of Social Services will be responsible for:
  - a. DSS will pay through the MMIS 100% of the cost of education and related services provided to children resident in non-state operated ICFs/DD, in accordance with reimbursement rates developed OMRDD utilizing data provided by SED in accordance with paragraph 1(b).
  - b. DSS will pay the federal share of the cost of education and related services provided to children resident in state operated ICFs/DD, in accordance with reimbursement rates developed by OMRDD utilizing data provided by SED in accordance with paragraph 1(b).
  - c. DSS shall consider the SED contribution made pursuant to paragraph 1(F) above to represent the full non-federal share contribution, and include all overburden obligations of counties pursuant to Social Services Law at Section 368-a.

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Supersedes TN NEW Effective Date JUL 1 1996

- d. DSS Shall hold SED responsible for any and all state and local share obligations incurred for education and [related services rendered under this memorandum.
  - e. DSS shall recover from SED the amount of any disallowance associated with any Medicaid payments made to any ICF/DD pursuant to this agreement.
4. State Education and the Office of Mental Retardation and Developmental Disabilities will be responsible for:
- a. Jointly maintain and share data on the location and number of school age persons who reside in ICFs/DD.
  - b. Jointly develop contracts between the ICF/DD and school districts, CRP programs and SED approved schools operated by ICFs/DD.
5. This memorandum shall continue in full force and effect until and unless it is terminated.
6. This memorandum may be amended only in writing and upon the mutual consent of the parties.
7. This memorandum shall be effective on July 1, 1995

TN 96 - 42 Approval Date OCT 28 1996  
Supersedes TN New Effective Date JUL -1 1996

1. It will be presumed that an individual will not return home if:
- (1) a person enters a skilled nursing or intermediate care facility;
  - (2) a person is initially admitted to acute care and is then transferred to an alternative level of care, pending placement in a residential care facility (RHCF); or
  - (3) a person without a community spouse remains in an acute care hospital for more than six calendar months.

The individual or his/her representative may submit medical statements providing evidence that s/he may reasonably be expected to return home, contrary to the presumption of permanent placement based on his/her residence in a medical institution. Should the argument that the placement is temporary be rejected by the social services district, the client or his/her representative may appeal the decision through the fair hearing process.

5. Notification:

Advance notification of estate recoveries is provided. Applicants are notified at the time of application that recoveries against their estates may be undertaken.

Recoveries from estates must be made in accordance with the procedures established under the Surrogate's Court Procedure Act (SCPA) with respect to claims against decedents' estates, including recoveries against estates which the social services district waives based upon undue hardship.

When asserting a recovery against the estate of a deceased Medical Assistance (MA) recipient, the social services district must notify the estate's representative in writing of the claim against the estate. This notice should be served on the estate's fiduciary within seven months of the issuance of letters testamentary or letters of administration by the Surrogate Court. The social services district should send the notice to the estate's fiduciary by personal delivery, or by certified mail, return receipt requested, pursuant to §1803 of the SCPA.

The notice sent by the social services district to the estate's fiduciary should set forth the amount of the claim, and must explain that if the representative asserts that the estate recovery would work an undue hardship upon the estate, the social services district may consider waiving the adjustment or recovery. The notice should advise that undue hardship may exist when:

- the estate asset subject to recovery is the sole income-producing asset of the beneficiaries, such as a family farm or family business, and income produced by the asset is limited;

TN 95-28 Approval Date SEP 27 1996

Supersedes TN **New** Effective Date APR 01 1995

- the estate asset subject to recovery is a home of modest value;
- there are other compelling circumstances.

The notice also should advise that undue hardship will not be found by the social services district where the hardship is the result of Medicaid or estate planning methods involving divestiture of assets, or where the only hardship that would result is the inability of any of the beneficiaries to maintain a pre-existing life-style.

Waiving recoveries based on undue hardship:

The estate fiduciary must give prompt written notice to the social services district of its rejection of the claim in part or in whole together with an explanation of the basis for the undue hardship. (See §1806 of the SCPA). Upon rejection of the claim by the fiduciary based upon undue hardship, if the social services district does not find a basis for the undue hardship, it may object to the claim rejection in an accounting proceeding or by petitioning the Surrogate Court to decide whether the claim should be paid.

In an accounting proceeding, the social services district may file an objection to the fiduciary's account which rejects its claim based on undue hardship, and have the validity of the claim determined by the Surrogate on this basis. (See §1808 of the SCPA). The social services district must file the objection to the account within eight days of receiving the fiduciary's notice of rejection based on undue hardship. (See §1808 of the SCPA). If the fiduciary has any affirmative defenses to the social services district's objection to the account, which were not set forth in the rejection served on the district, the fiduciary must reply setting forth the affirmative defenses within five days of the social service's district's service of its objection to the account. (See §1808 of the SCPA). Additionally, a beneficiary, or any other person whose interest in the estate would be adversely affected by allowance of the district's claim may, within eight days of the social services district's filing of its objection to the account, reply to the district's objection by setting forth any affirmative defense not set forth in the fiduciary's account. (See §1808 of the SCPA).

Alternatively, upon receiving notice that the estate's fiduciary has rejected the claim based upon undue hardship, if the social service district does not find adequate basis for waiving the recovery, it may petition the Surrogate Court within sixty days of the fiduciary's rejection of the claim showing the facts and requesting that the fiduciary show cause why the claim should not be allowed. (See §1810 of the SCPA).

TN 25-29 Approval Date SEP 27 1998  
Supersedes TN New Effective Date APR 01 1995

Where the fiduciary has not allowed the claim in whole, the social services district also may petition the Surrogate Court showing the facts of its claim and requesting that the fiduciary be ordered to show cause why the claim should not be allowed and paid, including in cases where it deems the claim rejected because the fiduciary has not allowed the claim within ninety days or has not served notice rejecting the claim within that period. (See §1809 of the SCPA). The fiduciary is then required to answer the petition, setting forth the basis for any undue hardship, within five days of being cited with the petition. (See §1809 of the SCPA).

Pursuant to §1809 of the SCPA, the estate fiduciary also may present a petition to the Surrogate Court showing the facts of a disputed claim, and requesting that the district be required to show cause why the claim should not be disallowed based upon undue hardship. The fiduciary also may petition the Surrogate Court pursuant to §1809 of the SCPA in cases where he or she is aware that a social services district may have a claim which the estate wishes to reject based upon undue hardship, but the social services district has failed to serve a notice of the claim. The social services district is then required to answer within eight days of being cited with the petition. The fiduciary then has five days from service of the answer by the social services district to serve and file a reply to the answer.

Cost-effectiveness Standards and Procedures:

The social services districts are authorized to make judgments as to the cost-effectiveness of recoveries based upon their knowledge of the amount of recovery from each type of recovery, and the costs of pursuing each type of recovery.

TN 95-28 Approval Date **SEP 27 1998**  
Supersedes TN **New** Effective Date **APR 01 1995**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

See Supplement to Attachment 4.17-A

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

A son or daughter can establish that he or she has been providing care which permitted the individual to reside at home by submitting evidence that he or she made arrangements or actively participated in arranging for care, either directly or indirectly, full-time or part-time.

3. The State defines the terms below as follows:

- o estate all real and personal property and other assets included within an individual's estate, and passing under the terms of a valid will or by intestacy.
- o individual's home the former principal place of residence owned by the permanently institutionalized individual or the deceased recipient.
- o equity interest in the home an individual's right to the use of and share in the proceeds from the sale of the property, as demonstrated by the presence of his/her name on the title.
- o residing in the home for at least one or two years on a continuous basis, and evidence that the relative was in residence on a regular basis for the continuous one or two years.
- o lawfully residing. the fact of the son or daughter's presence in the home as evidenced by postal, motor vehicle, or voting records or by the testimony of a neighbor or other party.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

4. The State defines undue hardship as follows: Undue hardship must be determined on a case by case basis. It includes (a) loss of a family farm or other family owned and operated business which is an income-producing asset, and (b) other compelling cases.
5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

See Supplement to Attachment 4.17-A

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness): Cost-effectiveness is determined by weighing the amount available for recovery against the expected cost of the recovery action. If finite resources are a factor, the amount of a given potential recovery less its cost must then be weighed against the potential net return of other recovery actions.
7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):  
Collection Procedures: TEFRA liens are filed against the homesteads of permanently institutionalized individuals. Liens are also filed against the estates of recipients who were permanently institutionalized or 55 years of age or older upon death.  
Advance Notification: Language on the Application for Public Assistance, Medical Assistance, Food Stamps, and Services now explains that a recovery may be sought for MA paid from the sale of the home of the applicant (if permanent institutionalized) or from his/her estate. The notification will also be placed in a pamphlet to be distributed at the time of application.  
Waiver Applications: These are filed as are any other disputed claims against estates through the State's Surrogate Court, which has jurisdiction over all matters related to estate settlements.  
Appeals: A living recipient's appeal regarding a property lien or other recovery action may be made by a conference with the social services district and/or the standard fair hearing process.  
Time Frames: All actions against the assets of living recipients are subject to timely notification requirements (at minimum ten days). A decedent's assets may not be distributed until at least six months after the appointment of an estate administrator.

TN No. 45-28

Supersedes

TN No. 42-22

Approval Date

SEP 27 1993

Effective Date

APR 01 1995

TN 92-28

Approval Date JAN 25 1994

Supersedes TN 85-33 Effective Date NOV 1 - 1993

Revision: HCFA-PH-05-14 (DERG)  
SEPTEMBER 1985

ATTACHMENT 4.10-A  
Page 1  
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Inpatient Hospital (defined here as article 28 and dually certified article 28 and 31 hospitals and out-of-state hospitals)			X	\$25 per recipient stay regardless of length of stay, payable at discharge. In no event is it expected that an inpatient hospital stay of one day would cost \$50 or less. Therefore, the State will meet the requirements of 42 CFR 447.54(c)

TN 92-28 Approval Date JAN 25 1994  
 Supersedes TN New Effective Date NOV 1 - 1993

Revision: HCFA-PM-05-14 (MERC)  
 SEPTEMBER 1985

ATTACHMENT 4.10-A  
 Page 1 a  
 OMB NO. 1 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Ambulatory Services as follows:				The basis for determination of co-payments for the following services was calculated by finding the average or typical dollar amount for a particular service. It was calculated by selecting a fixed period of time and dividing the identified total dollar value of the service by the number of claims, in accordance with 42 CFR 447.54 (a)(3)

TN 92-28

Approval Date JAN 25 1994

Supersedes TN New

Effective Date NOV 1 - 1983

Revision: HCFA-PR-85-14 (DRUG)  
SEPTEMBER 1985

ATTACHMENT 4.10-A  
Page 1 b  
OMB NO. 1 0930-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Outpatient Hospital - including non-emergency or non-urgent medical services			X	\$3
Diagnostic and Treatment Center (Free-standing clinics)			X	\$3
X-ray			X	\$1 each procedure
Laboratory			X	\$.50 each procedure
Medical/Sick Room Supplies			X	\$1 each order

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE New York

**OFFICIAL**

The following charges are imposed on the categorically needy for services:

SERVICE	TYPE OF CHARGE			AMOUNT AND BASIS FOR DETERMINATION
	DEDUCTIBLE	COINSURANCE	CO-PAY	
Pharmacy			X	\$3.00
1. Brand- name drugs			X	\$1.00
2. Generic drugs			X	\$0.50
3. Non-prescription drugs			X	\$1.00
4. Preferred brand name drugs <u>and brand name drugs, when cost after consideration of all rebates, is less than the generic equivalent</u>				

TN#: 09-52  
 Supercedes TN#: 08-42

Approval Date: MAR 12 2010  
 Effective Date: OCT 01 2009

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

B. The method used to collect cost sharing charges for categorically needy individuals:

Providers are responsible for collecting the cost sharing charges from individuals.

The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The recipient's own declaration that he/she is unable to pay is the basis for determining when an individual is unable to pay.

TN 92-28

Approval Date JAN 25 1994

Supersedes TN 85-33

Effective Date NOV 1 - 1993

- 1.) Children under age 21 are excluded based on a check of date of birth on the recipient file used during claim processing. The date of birth is printed on the plastic common benefit card.
- 2.) Pregnant women are excluded when requesting a service requiring copay. If not visibly apparent, a pregnant recipient can be determined by the type of drug or supply ordered, through a note signed by a physician which identifies the recipient as pregnant or through some other evidence which includes telephone contact with a physician or when the prescription source is a Prenatal Care Assistance Program (PCAP) or an obstetrician. The provider must indicate pregnancy on the claim form.
- 3.) Institutionalized individuals are identified and exempted during claims processing. These recipients usually do not leave the facility where they are institutionalized. When recipients require outside services, the facility makes arrangements and verifies the recipient exemption from copay.
- 4.) Emergency services are excluded by the providers indicating that the service is an emergency on the claim form.
- 5.) Family planning drugs and supplies are excluded from copay and are currently identified in the Provider Manuals under the headings of "Family Planning Products." Family planning items are also identified in the MMIS during claims processing.

TN 92 - 28 Approval Date JAN 25 1994  
Supersedes TN New Effective Date NOV 1 - 1993

**OFFICIAL**

Supplement 1  
Attachment 4.18-A  
Page 2

- 6.) Services provided by an HMO to an enrollee are identified [via] by the Electronic Medicaid Eligibility Verification System (EMEVS) to the provider of service. During claims processing, HMO enrollees and the services included in the capitation payment are identified as excluded.

Individuals enrolled in health maintenance organizations (HMO's) or other entities which provide comprehensive health services, or other managed care programs for services covered by such programs are exempt from co-payments, except that such persons shall be subject to co-payments for each generic prescription drug dispensed, each brand-name prescription drug dispensed, and each over-the counter medication ordered by a recognized practitioner as listed on Attachment 4.18-A, Page 1c.

- 7.) No service provided by a hospice is subject to co-pay. Services provided to individuals receiving hospice care are identified during MMIS claims processing and are exempted from co-pay requirements.

- 8.) Additional exclusions from co-payment may be made pursuant to state statute.

TN# 05-02

Approval Date: JUL 01 2005

Supersedes TN#: 92-28

Effective Date: APR 1 2005

- 1.) Children under age 21 are excluded based on a check of date of birth on the recipient file used during claim processing. The date of birth is printed on the plastic common benefit card.
- 2.) Pregnant women are excluded when requesting a service requiring copay. If not visibly apparent, a pregnant recipient can be determined by the type of drug or supply ordered, through a note signed by a physician which identifies the recipient as pregnant or through some other evidence which includes telephone contact with a physician or when the prescription source is a Prenatal Care Assistance Program (PCAP) or an obstetrician. The provider must indicate pregnancy on the claim form.
- 3.) Institutionalized individuals are identified and exempted during claims processing. These recipients usually do not leave the facility where they are institutionalized. When recipients require outside services, the facility makes arrangements and verifies the recipient exemption from copay.
- 4.) Emergency services are excluded by the providers indicating that the service is an emergency on the claim form.
- 5.) Family planning drugs and supplies are excluded from copay and are currently identified in the Provider Manuals under the headings of "Family Planning Products." Family planning items are also identified in the MMIS during claims processing.

TN 92-28 Approval Date JAN 25 1994  
Supersedes TN New Effective Date NOV 1 - 1993

**OFFICIAL**

Supplement 1  
Attachment 4.18-C  
Page 2

6.) Services provided by an HMO to an enrollee are identified [via] by the Electronic Medicaid Eligibility Verification System (EMEVS) to the provider of service.

During claims processing, HMO enrollees and the services included in the capitation payment are identified as excluded.

Individuals enrolled in health maintenance organizations (HMO's) or other entities which provide comprehensive health services, or other managed care programs for services covered by such programs are exempt from co-payments, except that such persons shall be subject to co-payments for each generic prescription drug dispensed, each brand-name prescription drug dispensed, and each over-the counter medication ordered by a recognized practitioner as listed on Attachment 4.18-C, Page 1c.

7.) No service provided by a hospice is subject to co-pay. Services provided to individuals receiving hospice care are identified during MMIS claims processing and are exempted from co-pay requirements.

8.) Additional exclusions from co-payment may be made pursuant to state statute.

TN# 05-02

Approval Date: JUL 01 2005

Supersedes TN#: 92-28

Effective Date: APR 1 2005

TN 92-28

Approval Date JAN 25 1994

Supersedes TN 85-33 Effective Date NOV 1 - 1993

Revisions HCFA-PM-85-14 (DRHC)  
SEPTEMBER 1985

ATTACHMENT 4.10-C  
Page 1  
OHV NO.: 0930-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

The following charges are imposed on the medically needy for services:

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Inpatient Hospital (defined here as article 28 and dually certified article 28 and 31 hospitals and out-of-state hospitals)			X	\$25 per recipient stay regardless of length of stay payable at discharge. In no event is it expected that an inpatient hospital stay of one day would cost less than \$50. Therefore, the State will meet the requirements of 42 CFR 447.51(c)

IN 92-20 APPROVAL DATE JAN 25 1994  
 SUPERSEDES THE NEW EFFECTIVE DATE NOV 1 - 1983

Revisions HGRA-716-14 (HRMC) SEPTEMBER 1985

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of New York

The following charges are imposed on the medically needy for services:

ATTACHMENT 4.10-C  
 Page 1 a  
 OHM NO.: 0930-0193

Service	Product, Type Charge	Copy.	Amount and Basis for Determination
Ambulatory Services as follows:			<p>The basis for determination of co-payments for the following services was calculated by finding the average or typical dollar amount for a particular service. It was calculated by selecting a fixed period of time and dividing the identified total dollar value of the service by the number of claim in accordance with 42 CFR 417.54 (a)(3)</p>

TN 92-28  
 Supersedes TN **New**  
 Effective Date NOV 1 - 1983  
 Approval Date JAN 25 1984

Revisions 118A-11-03-14 (MHC)  
 SEPTEMBER 1985

ATTACHMENT 4.18-C  
 Page 1 b  
 OIM NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

The following charges are imposed on the medically needy for services:

Service	Product.	Type Charge	Colno.	Copy.	Amount and Basis for Determination
Outpatient Hospital - including non-emergency or non-urgent medical services				X	\$3
Diagnostic and Treatment Center (Free-standing clinics)				X	\$3
X-Ray				X	\$1 each procedure
Laboratory				X	\$.50 each procedure
Medical/Sick Room Supplies				X	\$1 each order

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE New York

**OFFICIAL**

The following charges are imposed on the medically needy for services other than those provided under Section 1916 of the Act:

SERVICE	TYPE OF CHARGE			AMOUNT AND BASIS FOR DETERMINATION
	DEDUCTIBLE	COINSURANCE	CO-PAY	
Pharmacy			X	\$3.00
1. Brand- name drugs			X	\$1.00
2. Generic drugs			X	\$0.50
3. Non-prescription drugs			X	\$1.00
4. Preferred brand name drugs <u>and brand name drugs, when cost after consideration of all rebates, is less than the generic equivalent</u>				

TN#: 09-52  
 Supercedes TN#: 08-42

Approval Date: MAR 12 2010  
 Effective Date: OCT 01 2009

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

B. The method used to collect cost sharing charges for Medically needy individuals:

Providers are responsible for collecting the cost sharing charges from individuals.

The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The recipient's own declaration that he/she is unable to pay is the basis for determining when an individual is unable to pay.

TN 92-28 Approval Date JAN 25 1994  
Supersedes TN 85-33 Effective Date NOV 1 - 1993

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

ATTACHMENT 4.18-D  
Page 1  
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

\*Description provided on attachment.

TN No. 91-75  
Supersedes New Approval Date MAR 3 1992 Effective Date OCT 1 1991  
TN No. New

HCFA ID: 7986E

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

ATTACHMENT 4.18-D  
Page 2  
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

C. State or local funds under other programs are used to pay for premiums:

Yes

No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

\*Description provided on attachment.

TN NO. 91-75  
Supersedes 1507 Approval Date MAR 3 1992 Effective Date OCT 1 1991  
TN NO. 1507

HCFA ID: 7986E

Revision: HCFA-PM-91- (BPD)  
AUGUST 1991

ATTACHMENT 4.18-E  
Page 1  
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: New York

Optional Sliding Scale Premiums Imposed on  
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

\*Description provided on attachment.

TN No. 91-75  
Supersedes 178.337 Approval Date APR 8 1991 Effective Date OCT 1 1991

HCFA ID: 7986E

REVISION: HCFA-PM-91- - BPD  
AUGUST 1991

ATTACHMENT 4.9-E  
Page 2  
OMB No. 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

C. State or local funds under other programs are used to pay for premiums:  
 Yes  No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

\*Description provided on attachment.

TN No. 91-75  
Supersedes None Approval Date MAR 3 1992 Effective Date 01/01/92  
TN No. None  
HCFA ID: 0986E

Revision: HCFA-PM-85-14 (BERC)  
SEPTEMBER 1985

**OFFICIAL**

ATTACHMENT 4.18-C  
PAGE 3  
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York

D. The procedures for implementing and enforcing the exclusions [form] from cost-sharing contained in 42 CFR 447.53(b) are described below:

Informational notices and letters have been sent to providers, recipients and local social service districts.

MMIS Systems have been implemented to exclude certain groups of recipients from co-pay requirements as follows: SEE SUPPLEMENT 1.

E. CUMULATIVE MAXIMUMS ON CHARGES:

State policy does not provide for cumulative maximums.

Cumulative maximums have been established as described below:

From November 1, 1993 through March 31, 1994, a cumulative maximum of \$41 per Medicaid recipient will apply.

Beginning April 1, 1994 through March 31, 1995 and each following year beginning on April first a cumulative maximum of \$100 per Medicaid recipient will apply.

Beginning August 1, 2005 through March 31, 2006 and each following year beginning on April first, a cumulative maximum of \$200 per Medicaid recipient will apply.

TN#: 05-40

Approval Date: DEC 09 2005

Supercedes TN#: 92-28

Effective Date: AUG 01 2005

Revision: HCFA-PM-85-14 (BERC)  
SEPTEMBER 1985

**OFFICIAL**

ATTACHMENT 4.18-A  
PAGE 3  
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York

D. The procedures for implementing and enforcing the exclusions [form] from cost-sharing contained in 42 CFR 447.53(b) are described below:

Informational notices and letters have been sent to providers, recipients and local social service districts.

MMIS Systems have been implemented to exclude certain groups of recipients from co-pay requirements as follows: SEE SUPPLEMENT 1.

E. CUMULATIVE MAXIMUMS ON CHARGES:

State policy does not provide for cumulative maximums.

Cumulative maximums have been established as described below:

From November 1, 1993 through March 31, 1994, a cumulative maximum of \$41 per Medicaid recipient will apply.

Beginning April 1, 1994 through March 31, 1995 and each following year beginning on April first a cumulative maximum of \$100 per Medicaid recipient will apply.

Beginning August 1, 2005 through March 31, 2006 and each following year beginning on April first, a cumulative maximum of \$200 per Medicaid recipient will apply.

TN#: 05-40

Approval Date: DEC 09 2005

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Effective Date: \_\_\_\_\_

**OFFICIAL**

Attachment 3.1-A  
Supplement

**4b. Early and Periodic Screening, Diagnostic and Treatment services (EPSDT).**

School Supportive Health Services and Pre-School Supportive Health Services

School Supportive Health Services (SSHS) and Pre-School Supportive Health Services (PSSHS) are services provided by or through a school district, a Section 4201 school, a county in the State, or New York City to children with disabilities, who attend public or State Education Department approved schools or preschools. The services must be:

- medically necessary and included in a Medicaid covered category in accordance with 1905(a), 1905(r)(5), 1903(c) of the Social Security Act;
- ordered or prescribed by a physician or other licensed practitioner acting within his or her scope of practice under New York State Law;
- included in the child's Individualized Education Program (IEP);
- provided by qualified professionals under contract with or employed by a school district, a Section 4201 school, a county in the State or the City of New York;
- furnished in accordance with all requirements of the State Medicaid Program and other pertinent state and federal laws and regulations, including those for provider qualifications, comparability of services, and the amount, duration and scope provisions;  
and
- included in the state's plan or available under Early Periodic Screening, Diagnostic and Treatment (EPSDT) services.

Effective September 1, 2009, the services covered by the SSHS and PSSHS Program for Medicaid eligible children under the age of 21 who are eligible for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) include medically necessary physical therapy services, occupational therapy services, speech therapy services, psychological counseling, skilled nursing services, psychological evaluations, medical evaluations, medical specialist evaluations, audiological evaluations, and special transportation within the limits of EPSDT services. A school district, Section 4201 school, a county in the State, and New York City must be enrolled as a Medicaid provider in order to bill Medicaid.

**1. Physical Therapy Services**

**Definition:** Physical therapy services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

TN #09-61 \_\_\_\_\_  
Supersedes TN New \_\_\_\_\_

Approval Date APR 26 2010  
Effective Date SEP 01 2009

**OFFICIAL**

New York  
Page 2(xii)(B)

Attachment 3.1-A  
Supplement

Services: Physical therapy services provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York, must have a written order or prescription from a physician, physician assistant, or nurse practitioner who is acting within the scope of his or her practice under NYS law and must be provided to a child by or under the direction of a qualified physical therapist. Physical therapy services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures necessary to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Physical therapy services include but are not limited to:

- Identification of children with physical therapy needs;
- Evaluation for the purpose of determining the nature, extent and degree of the need for physical therapy services;
- Provision of physical therapy services for the purpose of preventing or alleviating movement dysfunction and related functional problems;
- Obtaining, interpreting, and integrating information appropriate to program planning;
- Diagnosis and treatment of physical disability, injury or disease using physical and mechanical means, including but not limited to, heat, cold, light, air, water, sound, electricity, massage, mobilization and therapeutic exercise with or without assistive devices, and
- The performance and interpretation of tests and measurements to assist pathopsychological, pathomechanical and developmental deficits of human systems to determine treatment and assist in diagnosis and prognosis.

Physical therapy services may be provided in an individual or group setting.

Providers: Services must be provided by:

- a New York State licensed and registered physical therapist qualified in accordance with 42 CFR 440.110(a) and with applicable state and federal laws and regulations, acting within his or her scope of practice under New York State Law; or
- a certified physical therapy assistant "under the direction of" such a qualified licensed and registered physical therapist, acting within his or her scope of practice under New York State Law.

TN #09-61 \_\_\_\_\_

Approval Date APR 26 2018

Supersedes TN New

Effective Date SEP 01 2008

**OFFICIAL**

Attachment 3.1-A  
Supplement

"Under the direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- sees the participant at the beginning of and periodically during the course of treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, at home and/or in community based settings.

## **2. Occupational Therapy Services**

**Definition:** Occupational therapy services as outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Occupational therapy services provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must have a written order or prescription from a physician, physician assistant, or nurse practitioner who is acting within the

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scope of his or her practice under New York State Law and must be provided to a child by or under the direction of a qualified occupational therapist. Occupational therapy services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Occupational therapy services include but are not limited to:

- Identification of children with occupational therapy needs;
- Evaluation for the purpose of determining the nature, extent and degree of the need for occupational therapy services;
- Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;
- Preventing through early intervention, initial or further impairment or loss of function;  
and
- Planning and utilization of a program of activities to develop or maintain adaptive skills designed to achieve maximal physical and mental functioning of the student in daily life tasks.

Occupational therapy services may be provided in an individual or group setting.

**Providers:** Services must be provided by:

- a New York State licensed and registered occupational therapist qualified in accordance with 42CFR 440.110(b) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State Law; or
- a certified occupational therapy assistant (COTA) "under the direction of" such a qualified licensed and registered occupational therapist, within his or her scope of practice under New York State Law.

"Under the direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- sees the participant at the beginning of and periodically during the course of treatment;

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- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be rendered in the settings in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, 4201 schools, state operated schools, in private practitioner's offices, at home and/or in community based settings.

**3. Speech Therapy Services**

**Definition:** Speech therapy services as outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Speech therapy services provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must have a written order or prescription from a physician, physician assistant, nurse practitioner, or a speech-language pathologist who is acting within his or her scope of practice under New York State law and must be provided to a child by or under the direction of a qualified speech-language pathologist. Speech therapy services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

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Speech therapy services include but are not limited to:

- Identification of children with speech disorders;
- Diagnosis and appraisal of specific speech disorders;
- Referral for medical or other professional attention necessary for the habilitation of speech disorders;
- Provision of speech or language services for the habilitation or prevention of communicative disorders;
- Evaluation and application of principles, methods and procedures of measurement, prediction, diagnosis, testing, counseling, consultation, rehabilitation and instruction, related to the development of disorders of speech, voice, and/or language, and
- Preventing, ameliorating or modifying speech disorder conditions in children and/or groups of children.

Speech therapy services may be provided in an individual or group setting.

**Providers:** Services must be provided by:

- a licensed and registered speech-language pathologist qualified in accordance with 42CFR Section 440.110(c) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law; or
- a teacher certified to provide speech and language services, under the documented direction of such a qualified licensed and registered speech language pathologist (ASHA-Certified or equivalent), acting within his or her scope of practice under New York State Law.

"Under the direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- sees the participant at the beginning of and periodically during the course of treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;

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- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, at home and/or in community based settings.

**4. Psychological Counseling**

**Definition:** Psychological counseling services outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Psychological counseling provided by or through a school district; a Section 4201 school; a county in the State or the City of New York must have a referral from a physician, physician assistant, or a nurse practitioner who is acting within the scope of his or her practice under NYS law or an appropriate school official or other voluntary health or social agency and must be provided to a child by or under the direction of a qualified practitioner. Psychological counseling services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Psychological counseling services include:

- treatment services using a variety of techniques to assist the child in ameliorating behavioral and emotional problems that are severe enough to require treatment.

Psychological counseling services may be provided in an individual or group setting.

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Providers: Psychological counseling services must be provided by a qualified practitioner, within his or her scope of practice in accordance with New York State Law and with the qualification requirements of 42 CFR Section 440.60(a) and 440.50(a)(2) and with other applicable state and federal laws or regulations. Psychological counseling services may only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological counseling services in the community.

Services may be provided by:

- a New York State licensed and registered psychiatrist qualified in accordance with 42 CFR Section 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law;
- a New York State licensed and registered psychologist qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law;
- a New York State licensed clinical social worker (LCSW), qualified in accordance 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law; or
- a licensed master social worker (LMSW) qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law, under the supervision of such a qualified licensed clinical social worker, a qualified licensed and registered psychologist, or a qualified licensed and registered psychiatrist as described above.

Supervision of the clinical social work services provided by the licensed master social worker, with respect to each Medicaid beneficiary, shall consist of contact between the licensed master social worker and supervisor during which:

- the licensed master social worker apprises the supervisor of the diagnosis and treatment of each client;
- the licensed master social worker's cases are discussed;
- the supervisor provides the licensed master social worker with oversight and guidance in diagnosing and treating clients;
- the supervisor regularly reviews and evaluates the professional work of the licensed master social worker; and
- the supervisor provides at least one hour per week or two hours every other week of in-person individual or group clinical supervision, provided that at least two hours per month shall be individual clinical supervision.

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Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, at home and/or in community based settings.

### **5. Skilled Nursing**

**Definition:** Skilled nursing services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Skilled nursing services provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York, must have a written order or prescription from a physician, physician assistant, or nurse practitioner acting within his or her scope of practice under New York State law and must be provided to a child by a registered nurse acting within his or her scope of practice under New York State law, or by a NYS licensed practical nurse acting within his or her scope of practice under New York State law "under the direction of" a NYS licensed and registered nurse or licensed physician, dentist or other licensed health care provider authorized under the Nurse Practice Act. Skilled nursing services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE) when there is a specific need based on a medical condition of the child.

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures necessary to correct and ameliorate physical defects, mental illnesses, and other disabilities.

Skilled nursing services include the promotion of health, prevention of illness, care of the ill and disabled people through the provision of services essential to the maintenance and restoration of health. Skilled nursing services may include:

- health assessments and evaluations;
- medical treatments and procedures;
- administering and/or monitoring medication needed by the student during school hours;  
and
- consultation with licensed physicians, parents and staff regarding the effects of medication.

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**Providers:** Skilled nursing services must be provided by:

- a New York State licensed registered nurse qualified in accordance with the requirements at 42 CFR 440.60(a) and other applicable state and federal law and regulations, acting within his or her scope of practice; or
- a New York State licensed practical nurse qualified in accordance with 42 CFR 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice "under the direction of" a licensed registered nurse, a physician, dentist or other licensed health care provider authorized under the Nurse Practice Act.

"Under the direction of" means that the licensed registered nurse, physician or other licensed health care provider authorized under the Nurse Practice Act:

- sees the participant at the beginning of and periodically during the course of treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be provided by:

- a New York State licensed and registered nurse; or
- a New York State licensed practical nurse, under the direction of a New York State licensed and registered nurse, or licensed physician, dentist or other licensed health care practitioner legally authorized under the Nurse Practice Act.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES)

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programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, and/or in community based settings.

## **6. Psychological Evaluations**

**Definition:** Psychological evaluations outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

Psychological evaluations provided by or through a school district; a Section 4201 school; a county in the State or the City of New York must have a referral from a physician, physician assistant, or nurse practitioner acting within his or her scope of practice under New York State law or an appropriate school official or other voluntary health or social agency and must be provided to a child by a qualified practitioner. Psychological evaluations must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a psychological evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

**Services:** Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Psychological evaluations include but are not limited to:

- Administering psychological tests and other assessment procedures;
- Interpreting testing and assessment results, and
- Evaluating a Medicaid recipient for the purpose of determining the needs for specific psychological, health or related services.

**Providers:** Psychological evaluations must be provided by a qualified provider who meets the requirements of 42 CFR Section 440.60 or 42 CFR Section 440.50(a) and other applicable state and federal laws and regulations. Psychological evaluation services may only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological evaluation services in the community.

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Services may be provided by:

- a New York State licensed and registered psychiatrist, qualified in accordance with 42CFR Section 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law; or
- a New York State licensed and registered psychologist, qualified in accordance with 42CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, and/or in community based settings.

## **Z. Medical Evaluations**

**Definition:** Medical evaluations outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Medical evaluations provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must be performed by a physician, physician assistant, or nurse practitioner acting within the scope of his or her practice under New York State law. A medical evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a medical evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

A medical evaluation is the recording of:

- chief complaints;
- present illness;

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- past medical history;
- personal history and social history;
- a system review
- a complete physical evaluation;
- ordering of appropriate diagnostic tests and procedures, and
- recommended plan of treatment

**Providers:** A medical evaluation must be provided by a New York State licensed and registered, physician, physician assistant, or nurse practitioner qualified in accordance with 42 CFR Section 440.50(a), 440.60(a) and 440.166(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice under NYS law.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, and/or in community based settings.

### **8. Medical Specialist Evaluations**

**Definition:** Medical specialist evaluations outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct and ameliorate physical defects, mental illnesses, and other disabilities.

Medical specialist evaluations provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must be provided by a New York State licensed and registered physician, physician assistant, or nurse practitioner specialist acting within his or her scope of practice and related area of specialization. A medical specialist evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a medical specialist evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

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A medical specialist evaluation is:

- an examination of the affected bodily area or organ system and other symptomatic or related organ systems;
- the ordering of appropriate diagnostic tests and procedures, and
- the reviewing of the results and reporting on the tests and procedures.

**Providers:** A medical specialist evaluation must be provided by a qualified New York State licensed and registered physician, physician assistant, or nurse practitioner specialist practicing in the related area of specialization within his or her scope of practice under NYS law, in accordance with 42CFR Section 440.50(a), 440.60(a), and 440.166(a) and other applicable state and federal laws and regulations.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, and/or in community based settings.

## **9. Audiological Evaluations**

**Definition:** Audiological evaluations as outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:** Audiological evaluations provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must have a written order from a physician, physician assistant, or nurse practitioner who is acting within the scope of his or her practice under NYS law and provided to a child by a qualified practitioner. An audiological evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If an audiological evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct and ameliorate physical defects, mental illnesses, and other disabilities.

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Medically necessary audiology services include but are not limited to:

- Identification of children with hearing loss;
- Determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for the amelioration of hearing; and
- determination of the child's need for group and individual amplification.

An audiological evaluation is the determination of the range, nature and degree of hearing loss including:

- measurement of hearing acuity;
- tests relating to air and bone conduction;
- speech reception threshold;
- speech discrimination;
- conformity evaluations;
- pure tone audiometry.

Providers: Audiology evaluation services must be provided by a New York State licensed and registered audiologist, qualified in accordance with 42 CFR Section 440.60(a) and 42CFR Section 440.110(c)(3) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

Services may be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, and/or in community based settings.

### **10. Special Transportation**

Definition: Special transportation outlined in this section of the State Plan is available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct and ameliorate physical defects, mental illnesses, and other disabilities.

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Services: Special transportation provided by or through a school district; a Section 4201 school; a county in the State or the City of New York must be included in the IEP as recommended by the Committee on Special Education (CSE), or the Committee on Preschool Special Education (CPSE). Special transportation arrangements must be identified in the IEP.

Special transportation is provided when a child requires specialized transportation equipment, supports or services because of his/her disability as cited in 34 CFR 300.34(c)(16)(iii).

Special transportation is limited to those situations where the child receives transportation to obtain a Medicaid covered service (other than transportation), and both the Medicaid covered service and the need for special transportation are included in the child's IEP. Special transportation can only be billed on a day that a Medicaid reimbursable service was delivered and may only be billed at the rate for each one way trip.

Providers: Special transportation services must be provided by a qualified Medicaid provider. Attendance documentation (bus logs) is required in order to bill Medicaid. In order to receive payment for services provided to a Medicaid recipient, a vendor must be lawfully authorized to provide transportation services on the date the services are rendered.

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6d. Other Practitioner Services (Continued)

Pharmacists as Immunizers

1. Reimbursement will be provided to pharmacies for vaccines and anaphylaxis agents administered by certified pharmacists within the scope of their practice.
2. Service setting.  
Services will be provided by a certified pharmacist in a pharmacy or in other locations where mass immunization may take place, such as retail stores/outlets, assisted living centers, and health fairs.
3. Provider qualifications.  
Pharmacists must be currently licensed, registered and certified by the NYS Department of Education Board of Pharmacy to administer immunizations.

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6d. Nurse Practitioners' Services

New York State covers all nurse practitioner specialties recognized under State Law with no limitations.

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- 6b. Prior approval is required for orthoptic training.
- 6c. Chiropractor services. Provision of chiropractic services shall be limited to EPSDT recipients by medical necessity. Services shall be provided to the extent that such services result from the referral of the recipient's physician or primary care clinic.
- 6d. Clinical psychologists. Provision of clinical psychology services shall require referral by:
1. The patient's personal physician or medical resource, such as a clinic, acting as the patient's physician;
  2. the medical director in an industrial concern;
  3. an appropriate school official;
  4. an official or voluntary health or social agency.
- 7a. Home care services are medically necessary services (physician order required) provided by a Certified Home Health Agency (CHHA) to individuals in the home and community. Such services include both part time and intermittent skilled health care and long-term nursing and home health aide services. Home (health) care services include nursing, home health aide, physical therapy, occupational therapy, and speech therapy. Patients must be assessed as being appropriate for intermittent or part-time nursing services ordered by a physician pursuant to a written plan of care provided by a home health agency upon admission to an Assisted Living Program (ALP), no later than 45 days from the date of admission, and at least once during each subsequent six month period. The social services district must review the assessment and prior authorize the service.

Providers of home (health) care services must possess a valid certificate of approval issued pursuant to the provisions of Article 36 of the Public Health Law, be certified in accordance with certified home health agency, long term home health care program and AIDS home care program certification and authorization and provide services in accordance with minimum standards.

Home (health) care services provider qualifications are provided for registered professional nurse, home health aide, physical therapist, occupational therapist and speech pathologist.

Registered professional nurse shall mean a person who is licensed and currently registered as a registered professional nurse pursuant to Article 139 of the New York State Education Law.

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The State assures the provision of Home Health services will be provided in accordance with 42 CFR 440.70.

- 7b. Patients must be assessed as being appropriate for home health aide services ordered by a physician pursuant to a written plan of care provided by a home health agency upon admission to an Assisted Living Program (ALP), no later than 45 days from the date of admission, and at least once during each subsequent six month period. The social services district must review the assessment and prior authorize the service.

Home Health aide shall mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care needs in his/her home. Home health aides shall have successfully completed a basic training program in home health aide services or an equivalent exam approved by the Department and possess written evidence of such completion.

Certified home health agencies may provide home health services to individual's diagnosed by a physician as having AIDS and are not required to hold a specific designation for providing home health services to AIDS patients.

Providers of AIDS home care services must possess a valid certificate of approval issued pursuant to the provisions of Article 36 of the Public Health Law (PHL), or a residential health care facility or hospital possessing a valid operating certificate issued under Article 28 of the PHL which is authorized under Article 36 of the PHL to provide an AIDS home care program; or an AIDS Center, specifically authorized pursuant to Article 36 of the PHL to provide an AIDS home care program, be certified in accordance with certified home health agency certification and authorization pursuant to sections 3606, 3611 and 3612 of PHL and provide services in accordance with minimum standards pursuant to section 3612 of PHL. Such an agency or program must participate as a home health agency under the provisions of Titles XVIII and XIX of the Federal Social Security Act.

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AIDS home care services providers qualifications are provided pursuant to Article 36 of the PHL.

The [S]state assures the provision of AIDS home care services will be provided in accordance with 42 CFR 440.70 (for the provision of home health services).

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**Home Telehealth Services**

Beginning on October 1, 2007, the Commissioner of Health is authorized to establish fees to reimburse the cost of home telehealth services provided by a certified home health agency, including those that provide AIDS home care services.

The Commissioner shall reimburse for telehealth services if such services are provided only in connection with federal Food and Drug Administration approved and interoperable devices, which are incorporated as part of a patient's plan of care.

The purpose of providing telehealth services shall be to assist in the effective monitoring and management of patients whose medical, functional, and/or environmental needs can be appropriately and cost-effectively met at home through the application of telehealth intervention.

Reimbursement for home telehealth services is to be provided for Medicaid patients with conditions or clinical circumstances associated with the need for frequent monitoring, and/or the need for frequent physician, skilled nursing or acute care services, and where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits or acute long term care facility admissions. Conditions or clinical circumstances shall include, but not be limited to, congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding.

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**Attachment 3.1-A  
Supplement**

7c. Certain specialty items require prior approval. These items are identified for equipment dealers in the MMIS DME Provider Manual. Prior approval is required for most repairs to durable medical equipment. Personal Emergency Response Services (PERS) are provided according to [LDSS] Local Social Services District (LSSD) written authorization for recipients of personal care services and home health services ordered by a physician pursuant to a written plan of care.

7d. Physical therapist shall mean a person who is licensed by and currently registered with the New York State Education Department or who has been issued a valid limited permit by that Department. The state assures the provision of physical therapy services will be provided in accordance with 42 CFR 440.110(a)(2)(i) and 440.110(a)(2)(ii).

Occupational therapist shall mean a person who is registered with the American Occupational Therapy Association, or either a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association or a graduate of a curriculum in occupational therapy which is recognized by the World Federation of Occupational Therapists and is eligible for a registration with the American Occupational therapy Association. The state assures the provision of occupational therapy services will be provided in accordance with 42 CFR 440.110(b)(2)(i) and 440.110(b)(2)(ii).

Speech pathologist shall mean a person who is licensed as required by Article 159 of the New York State Education Law. The state assures the provision of speech therapy services will be provided in accordance with 42 CFR 440.110(c)(2).

8. Private Duty Nursing (PDN) is medically necessary nursing services, ordered by and in accordance with a written physician's treatment plan, provided in a person's home on a continuous basis normally considered beyond such nursing services available from a Certified Home Health Agency (CHHA) or intermittent nursing services normally provided through a CHHA but which are unavailable. Prior approval is required for private duty nursing services either in a person's home or in a hospital except in an urgent situation in which the attending physician may order the services for no more than two nursing days.

Care and services of a private duty nurse will be provided only if they are in accordance with the regulations of the Department of Health.

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Supplement**

Service providers who provide private duty nursing include a Licensed Home Care Services Agency's (LHCSA) registered nurses (RN) or licensed practical nurses (LPN) enrolled on an independent practitioner basis.

Nurses providing PDN must possess a license to practice in the State of New York and be currently registered by the New York State Education Department (NYSED). In addition, nurses providing an appropriate attestation regarding their training and ability to care for medically fragile children receive a Specialty code on their file entitling them to increased reimbursement for the provision of such care.

The [S]tate assures that the provision of PDN will be provided in accordance with 42 CFR 440.80.

9. Clinic services provided in Article 28 clinics are in accordance with 42 CFR §440.90 titled clinic services. Requirements for physicians supervision comply with the [S]tate Medicaid Manual, §4320B titled Physician Direction Requirement.

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10. Prior approval is required for all dental care except preventive prophylactic and other routine dental care services and supplies.

12a. Prior authorization or dispensing validation is required for some prescription drugs. The State has established a preferred drug program with prior authorization for drugs not included on the preferred drug list. The prior authorization complies with the requirements of Section 1927 (d)(5) of the Social Security Act and provides for a 24-hour turnaround by either telephone or other telecommunications device from receipt of request and provides for a 72-hour supply of drugs in emergency circumstances. In addition, brand-name drugs that have a FDA approved, A-rated generic equivalent must be prior authorized unless exempted by the Commissioner of Health. Prior authorization is required for a generic equivalent of a brand name drug, including a generic equivalent that is on the preferred drug list or the clinical drug review program, when the net cost of the brand-name drug, after consideration of all rebates, is less than the cost of the generic equivalent.

Drugs for which Medical Assistance reimbursement is available are limited to the following:

1. Outpatient drugs of any manufacturer which has entered into and complies with a rebate agreement under Sections 1902(a) (54) and 1927 (a) of the Act with the Centers for Medicare and Medicaid Services (CMS) which are prescribed for a medically accepted indication. All drugs covered by the National Drug Rebate Agreements remain available to Medicaid beneficiaries, although some may require prior authorization. Drugs for the treatment of erectile dysfunction, as set forth in 42 U.S.C. § 1396r-8(d)(2)(K), are not a covered service, on and after April 1, 2006, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and these uses have been approved by the Food and Drug Administration.

2. Supplemental Rebate Programs

The State is in compliance with Section 1927 of the Social Security Act. The State has the following policies for the Supplemental Rebate Programs for the Medicaid population.

a) CMS has authorized the State of New York to enter into the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the Amendment to the SRA submitted to CMS on March 30, 2006 have been authorized for pharmaceutical manufacturers' existing agreements through their current expiration dates. The updated NMPI SRA submitted to CMS on March 20, 2008 has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.

b) CMS has authorized the State of New York to enter into Medicaid State-specific Supplemental Rebate Agreement directly with manufacturers to receive supplemental rebates of covered outpatient drugs for Medicaid beneficiaries. The State-specific Supplemental Rebate Agreement was submitted to CMS on March 31, 2010 and has been authorized by CMS.

[b)] c) The prior authorization process complies with the requirements of Section 1927 of the Social Security Act and provides for a 24-hour turn-around response by either telephone or telecommunications device from the receipt of a prior authorization request. In emergency situations, providers may dispense a 72-hour supply of medications.

[c)] d) The terms of the supplemental rebate programs apply only to covered outpatient drugs for which the State is eligible for federal financial participation. Supplemental rebates received by the State in excess of those required under the National Drug Rebate Program will be shared with the Federal Government on the same percentage basis as applied under the National Drug Rebate Agreement.

[d)] e) Any [contracts] Supplemental Rebate Agreement not [approved] authorized by CMS will be submitted to CMS for [approval] authorization.

[e)] f) All drugs covered by the programs will comply with the provisions of the national drug rebate agreement.  
3. Any changes to the NMPI Supplemental Rebate Agreement must be submitted to CMS for [approval] authorization. Any changes to the State-specific Supplemental Rebate Agreement NY State holds directly with the manufacturer must be submitted to CMS for authorization.

4. As provided by the Act, a new drug manufactured by a company which has entered into a rebate agreement may be covered subject to prior approval, unless the drug is subject to the allowable exclusion categories provided by the Act.

5. As specified in Section 1927(b)(3)(D) of the Act, notwithstanding any other provisions of law, rebate information disclosed by a manufacturer shall not be disclosed by the state for purposes other than rebate invoicing and verification.

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[2.]16. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

[3.]17. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit -Part D.

X The following excluded drugs are covered:

- (a) agents when used for anorexia, weight loss, weight gain
- (b) agents when used to promote fertility
- (c) agents when used for cosmetic purposes or hair growth
- X (d) agents when used for the symptomatic relief cough and colds: Some—benzonatate only
- X (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride: Some—select B Vitamins (niacin, pyridoxine, thiamine, cyanocobalamin); Folic Acid; Vitamin K; Vitamin D (ergocalciferol, cholecalciferol); Iron (including polysaccharide iron complex); Iodine
- X (f) nonprescription drugs: Some—select allergy, asthma and sinus products; analgesics; cough and cold preparations; digestive products; insulin; feminine products; topical products; smoking cessation products, minerals and vitamin combinations
- (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- X (h) barbiturates: All
- X (i) benzodiazepines: All
- X (j) smoking cessation for non-dual eligibles as Part D will cover: All

12b. Prior approval is required for all dentures.

12c. Prior approval is required for prosthetic and orthotic devices over a dollar amount established by the State Department of Health and identified for providers in the MMIS DME Provider Manual.

Prior approval is required for artificial eyes as specified in the MMIS Ophthalmic Provider Manual.

Program also includes coverage of orthotic appliances including hearing aids. All hearing aids require prior approval.

12d. Prior approval is required for certain special lenses and unlisted eye services as specified for providers in the MMIS Ophthalmic Provider Manual.

13a. Diagnostic Services (see 13.d Rehabilitative Services – Early Intervention).

13b. Screening Services (see 13.d Rehabilitative Services – Early Intervention).

13c. Preventive Services (see 13.d Rehabilitative Services – Early Intervention).

13d. Rehabilitative Services

(1) Directly Observed Therapy (DOT) – Clients must be assessed as medically appropriate for DOT based upon the client's risk of non adherence to a medication regimen necessary to cure an active, infectious, potentially fatal disease process and to prevent the development and spread of an infectious, potentially fatal disease which may not respond to conventional therapies.

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*under 05-52, this pg was  
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**Attachment 3.1-A Supplement Page 2d**

"Off-site" services shall be provided to developmentally disabled persons whose therapeutic requirements are most effectively satisfied in an appropriate environment that is specific to the treatment needs of the developmentally disabled individual. Such services shall be provided by persons authorized pursuant to NYCRR Title 14 Part 679. "Off-site" services shall not be provided at the location of a clinic certified by NYCRR Title 14 Part 679.

"Early Intervention" Services are provided to children who have or who are suspected of having a developmental delay or disability. These services, limited to EPSDT, which are provided by or on behalf of a county or the City of New York pursuant to an Individualized Family Services Plan (IFSP) include:

- |                       |   |  |
|-----------------------|---|--|
| 1. Screening          | 6. Occupational Therapy   | 11. Speech Pathology Services                            |
| 2. Evaluation         | 7. Physical Therapy   | 12. Assistive Technology Services                        |
| 3. Audiology          | 8. Psychological Services   | 13. Vision Services                                      |
| 4. Nursing            | 9. Social Work Services   | 14. Collateral contacts for all of the<br>above services |
| 5. Nutrition Services | 10. Anticipatory Guidance<br>(Special Instruction and Allied Health<br>Professional Assistance) |  |

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13.d (Cont'd) Rehabilitative services for residents of community-based residential programs licensed by the Office of Mental Health (OMH) are of three types:

1. Community residences of sixteen beds or less;
  2. Family-based treatment and
  3. Teaching family homes.
1. Community Residences

Rehabilitative services in community residences are interventions, therapies and activities which are medically therapeutic and remedial in nature, and are medically necessary for the maximum reduction of functional and adaptive behavior deficits associated with the person's mental illness. Community residences for adults may be either a congregate-type arrangement or apartment-based. Community residence services are also provided to children.

Limitations on services include the following:

- All providers must be currently licensed by OMH as community residences under 14 NYCRR 586 and 594. Congregate locations have sixteen beds or less.
- Adults admitted must be determined to have a severe and persistent mental illness, as defined by the Commissioner of OMH.
- Children admitted must be determined to have a serious emotional disturbance, as defined by the Commissioner of OMH.
- Services are limited to those described in 14 NYCRR 593.
- All services must be provided pursuant to a physician's written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593.

2. Family-based treatment

Rehabilitative services in family-based treatment programs are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child's developmental stage. Those children determined eligible for admission are placed in surrogate family homes for care and treatment.

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Supersedes TN 93-16 Effective Date APR 1 - 1994

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Limitations on services include the following:

- all providers must be currently licensed by OMH as family-based treatment programs under 14 NYCRR 594.
- children admitted must be determined to have a serious emotional disturbance, as defined by the Commissioner of OMH.
- services are limited to those described in 14 NYCRR 593.
- all services must be provided pursuant to a physician's written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593.

### 3. Teaching Family Homes

Rehabilitative services in teaching family homes are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child's developmental stage. Eligible children are placed in small congregate care homes (4 children or less) in a supervised living arrangement with approved teaching parents, based on the National Teaching Family Model.

This program is different from family based treatment because some children are not able to tolerate the family closeness of family based treatment programs, and, therefore, are more appropriately treated in teaching family homes.

Limitations on services include the following:

- All providers must be currently licensed by OMH as teaching family homes under 14 NYCRR 594.
- Children admitted must be determined to have a serious emotional disturbance, as defined by the Commissioner of OMH.
- Services are limited to those described in 14 NYCRR 593.
- All services must be provided pursuant to a physician's written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593.

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13d. Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) programs will provide case management, treatment and rehabilitation to persons with a serious psychiatric disorder who exhibit a pattern of institutional utilization and/or are at risk of a severely dysfunctional lifestyle; present symptoms and impairments not effectively remedied by other available treatment; do not or cannot be engaged in treatment in other outpatient settings as a result of their mental illness; or cannot maintain consistency in treatment through other outpatient services.

Programs will be licensed under 14 NYCRR Part 508. Services will be provided primarily in the community. Services will be provided by a licensed multi-disciplinary team under the supervision of a psychiatrist which meets with the recipient or the recipient's significant others a minimum of six times per month. Of these six contacts, at least three of the contacts must be with the Medicaid recipient. Step down services may be provided to clients found by the team to be no longer in need of full ACT team services. A client who is receiving ACT step down must receive a minimum of two face to face contacts per month. Individuals shall be allowed to alternate between the full ACT team services and step-down services depending on the level of services needed to remain in the community.

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**OFFICIAL**Attachment 3.1-A  
Supplement  
Page 3b-2**13 d. Rehabilitative Services**  
**Personalized Recovery Oriented Services**

A comprehensive Personalized Recovery Oriented Services (PROS) program will provide Community Rehabilitation and Support, Intensive Rehabilitation and Ongoing Rehabilitation and Support. A "limited license" will be made available for free-standing Intensive Rehabilitation and Ongoing Rehabilitation and Support programs that are operated by a provider that does not have the capability to offer Community Rehabilitation and Support.

Community Rehabilitation and Support (CRS) is designed to engage and assist individuals in managing their mental illness and in restoring those skills and supports necessary to live successfully in the community. Intensive Rehabilitation (IR) is a customized package of rehabilitation and support services designed to intensely assist an individual in attaining specific life goals such as successful completion of school, attainment of stable and independent housing, and gainful employment. Intensive Rehabilitation services may also be used to provide targeted interventions to reduce the risk of hospitalization, loss of housing, involvement in the criminal justice system, and to help individuals manage their symptoms. Ongoing Rehabilitation and Support (ORS) will provide interventions designed to assist in managing symptoms in an integrated workplace setting.

PROS programs will offer a comprehensive menu of services, customized for each client through development of an individualized recovery plan. Services provided by the CRS component of a PROS program will include but are not limited to: engagement; assessment; wellness self-management; basic living skills training; benefits and financial management; community living skills exploration; crisis intervention; individual recovery planning; information and education regarding self help; and structured skill development and support. Services provided by the IR component of a PROS program will include but are not limited to: family psychoeducation; intensive rehabilitation goal acquisition; clinical counseling and therapy; and intensive relapse prevention. Service provided in the IR component of a "limited license" PROS program will include, but is not limited to, intensive rehabilitation goal acquisition for employment and education-oriented goals. Services provided by the ORS component of a PROS program will include, but are not limited to, vocational support services, defined as the ongoing provision of counseling, mentoring and advocacy services designed to sustain an individual's role in integrated employment by providing supports which assist the individual in symptom management. PROS services will be provided both onsite and offsite, but ORS services will always be provided off-site in the community.

Programs may, at their option, provide clinical treatment services designed to stabilize, ameliorate and control the disabling symptoms of mental illness. Programs that provide clinical treatment services will be reimbursed at a higher rate for the clinic component than programs which do not provide clinical treatment services.

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Page 3b-3

**13 d. Rehabilitative Services**  
**Personalized Recovery Oriented Services-continued**

The goal of the program is to provide integrated services, but clients can choose to receive services from different service components in more than program. Clients enrolled in a PROS program which provides clinical treatment services will be given free choice as to whether they wish to receive clinical treatment through the PROS program, or receive those services from a clinic licensed under 14 NYCRR Part 587.

Programs will be licensed and reimbursed under criteria set forth in 14 NYCRR Part 512. Staffing requirements will include differing staff to client ratios depending on the component of services the program offers.

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Rehabilitative Services (cont.)

"Off-site" services shall be provided to developmentally disabled persons whose therapeutic requirements are most effectively satisfied in an appropriate environment that is specific to the treatment needs of the developmentally disabled individual. Such services shall be provided by persons authorized pursuant to NYCRR Title 14 Part 679. "Off-site" services shall not be provided at the location of a clinic certified by NYCRR Title 14 Part 679.

18. Limitations on Hospice Services:

Hospice services are provided to individuals who are certified [Recipients must be diagnosed] by a physician as being terminally ill, [that is, having] with a life expectancy of approximately six months or less [to live].

Recipients must sign an Informed consent electing hospice over conventional care, subject to periodic review.

Services [must be] provided [in accordance with pertinent Department of Health regulations] are palliative in nature as opposed to curative: Services include supportive medical, social, emotional, and spiritual services to terminally ill individuals as well as emotional support for family members. Hospice services may be delivered at home, in a nursing home or in a hospice residence.

Recipients who elect hospice care waive all rights to Medicaid reimbursement made on their behalf for the duration of the election of any services covered under the Medicaid State Plan that are related to the treatment of the terminal condition for which hospice care was elected, or a related condition.

Hospice services provider qualifications are provided for registered professional nurse, home health aide, physical therapist, occupational therapist, speech pathologist, personal care aide, housekeeper/homemaker, pastoral care coordinator, social worker, nutritionist, audiologist, and respiratory therapist, personal care aid, housekeeper/homemaker, pastoral care coordinator, social workers, nutritionist, audiologist, and respiratory therapist.

Registered professional nurse shall mean a person who is licensed and currently registered as a registered professional nurse pursuant to Article 139 of the New York State Education Law.

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New York  
3(c)(1)

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Home Health aide shall mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care needs in his/her home. Home health aides shall have successfully completed a basic training program in home health aide services or an equivalent exam approved by the Department and possess written evidence of such completion.

Physical therapist shall mean a person who is licensed by and currently registered with the New York State Education Department or who has been issued a valid limited permit by that Department.

Occupational therapist shall mean a person who is registered with the American Occupational Therapy Association, or either a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association or a graduate of a curriculum in occupational therapy which is recognized by the World Federation of Occupational Therapists and is eligible for a registration with the American Occupational Therapy Association.

Speech pathologist shall mean a person who is licensed as required by Article 159 of the New York State Education Law.

Personal care aide shall mean a person who, under professional supervision, provides patients assistance with nutritional and environmental support and personal hygiene, feeding and dressing and/or, as an extension of self-directed patients, selects health-related tasks. A personal care aide shall have successfully completed:

- (i) a training program in home health aide services or equivalent exam as specified in the description for home health aide above; or
- (ii) one full year of experience in providing personal care services through a home care services agency within three years preceding the effective date of an initial license issued pursuant to Article 36 of the Public Health Law; or
- (iii) a training program in personal care services approved by the New York State Department of Health, which shall include basic training, periodic and continuing in-service training, and on-the-job instruction and supervision; and

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3(c)(ii)

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In those instances where the personal care aide is to be providing assistance with health-related tasks, such aide shall be trained as described in subparagraph (iii) of this paragraph and training in health-related tasks shall be completed in full prior to the personal care aide's assignment to any patient, as evidenced by written documentation of such completion.

Homemaker shall mean a person who meets the standards established by the Department of Social Services and assists and instructs persons at home because of illness, incapacity or absence of a caretaker relative in providing assistance with environmental and nutritional tasks.

Pastoral care coordinator shall mean a person who has had a minimum of one year of training and experience in pastoral/spiritual counseling, and has a baccalaureate degree from a regionally accredited college or university or one recognized by the New York State Department of Education.

Social worker shall mean a person who holds a master's degree in social work after successfully completing a prescribed course of study at a graduate school of social work accredited by the Council on Social Work Education and the Education Department, and who is certified or licensed by the Education Department to practice social work in the State of New York. When employed by a certified home health agency, long-term home health care program or hospice, such social worker must have had one year of social work experience in a health care setting.

Nutritionist shall mean a person who applies the principles of normal and therapeutic nutrition and of the physical, biological, social and behavioral sciences to the assessment and management of those factors in the personal community environment which influence nutritional status. A nutritionist must possess a baccalaureate degree, with major studies in food and nutrition, from a regionally accredited or New York State registered four-year college or university, and be registered or be eligible for registration by the American Dietetic Association.

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3(c)(iii)

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Audiologist shall mean a person who is licensed as required by Article 159 of the New York State Education Law.

Respiratory therapist shall mean a person who is licensed and currently registered as a respiratory therapist pursuant to Article 164 of the New York State Education Law.

Providers of Hospice Services must be certified in accordance with Article 40 of the PHL. Services are provided in accordance with 42 CFR Part 418.

The State assures the provision of Hospice services will be provided in accordance with 42 CFR Part 418.

19. Limitations on Tuberculosis related services:

Directly Observed Therapy (DOT) – will be provided to clients who are being treated for Tuberculosis Disease.

22. Limitation on Respiratory Care:

Services may be rendered to EPSDT population by medical necessity and that services is furnished through the clinic and home benefits to this population.

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**OFFICIAL**

- 24a. Prior approval is required for non-emergent transportation, including the services and subsistence of the attendant. Requests can be made by recipients or their family members; or medical practitioners acting on behalf of a recipient.

Transportation providers are assigned to requests for non-emergency transportation services based upon first, a recipient's choice of available participating vendors at the medically appropriate level of transportation; then, if the recipient indicates no preference, the ordering practitioner's choice among available participating vendors at the medically appropriate level of transportation; and finally, if no choice is made by the ordering practitioner, the request is given via rotation among the medically available and appropriate mode of transportation providers.

1. To assure comparability and statewideness, each county's local department of social services manages transportation services on behalf of recipient's assigned to the county.
2. Recipient, family member, or volunteer reimbursement is made as an administrative expense of the Medicaid Program. This applies to any personal vehicle mileage reimbursement, lodging, airfare, or other expense borne on behalf of the Medicaid recipient by a non-direct vendor.

- 24d. Prior approval is required for skilled nursing facility services except when admitted directly from a hospital, another skilled nursing facility or from a health related facility.

Medicaid payments shall not be authorized for skilled nursing facilities which are not certified or have not applied for certification to participate in Medicare.

26. Personal Care Services means some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Prior approval is required for all personal care services. The authorization period and amount of personal care services authorized depends upon patient need, as indicated in the patient's assessment.

Personal care services, shared aide and individual aide, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.

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Providers of personal care services (personal care aides) must have:

- maturity, emotional and mental stability, and experience in personal care or homemaking;
- the ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records;
- a sympathetic attitude toward providing services for patients at home who have medical problems;
- good physical health, as indicated by the documentation in the personnel file of all persons providing personal care services. This documentation must include the same assurances and proof of good physical health that the Department of Health requires for employees of certified home agencies;
- a criminal history record check performed to the extent required under section 124 of the PHL; and
- successfully completed a training program approved by the Department.

Personal care aides must be supervised by a registered professional nurse who is licensed and currently certified to practice in New York State and who has at least two years satisfactory recent home health care experience. Nursing supervision includes orienting the personal care aide to his/her job assignment(s); providing needed on-the-job training; making nursing supervisory visits to the patient's home PRN, but at least every 90 days; and, annually conducting an overall job performance evaluation of the aide.

New York State's Personal Care Services are provided in accordance with 42 CFR 440.167.

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Attachment 3.1-A  
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(07/07)

26 (cont.). Consumer Directed Personal Assistance Program

The Consumer Directed Personal Assistance Program (CDPAP) is a consumer directed home care services delivery model. The program serves Medicaid recipients who have a medical need for home care services and who choose to participate in this model. It has operated under the State's Personal Care Services benefit since 1990. As such, the eligibility, assessment and prior authorization of services processes mirror that of the Personal Care Services Program (PCSP). In the traditional PCSP, the local social services district (LSSD) contracts with home care agencies for the provision of services. The home care agency is responsible for hiring, training, supervising, and providing the home care worker with salary and benefits. In the CDPAP a local social services district contracts with a CDPAP agency and there is a co-employer relationship between the CDPAP agency and the consumer that encompasses these functions. The CDPAP consumer is responsible for hiring/training/supervising/and firing his/her aides. The CDPAP agency acts as the co-employer of each aide hired by the consumer for the purpose of setting wage levels and fringe benefits, including health insurance coverage and other benefits, e.g. unemployment and workers compensation. It is the CDPAP agency that actually pays each aide and administers related fringe benefits. The CDPAP agency also submits claims for payment to the Department's agent that processes and pays claims for services provided to Medicaid recipients.

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**New**

27. The State elects to provide medical assistance services to eligible individuals through a Primary Care Case Management Program. PCCMs are responsible for locating, coordinating, and monitoring covered primary care to all individuals enrolled with a case manager.

PCCM providers may be physicians, physician group practices, entities employing or having other arrangements with physicians to provide PCCM Services under the contract. Nurse practitioners may also be a PCCM provider.

A PCCM will provide for arrangements with, or referrals to a sufficient number of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

PCCMs are required to be accessible 24 hours/seven days per week to provide information, referral and treatment to enrollees. PCCMs may not restrict an enrollees access to emergency services, or require prior authorization of emergency services.

A PCCM shall be geographically accessible to enrollees. Primary care providers must meet State standards for travel time and distance.

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TN NO. 00-43  
Supercedes  
TN

Approval Date

Effective Date **OCT 01 2000**

TN 00-43 Approval Date MAR 28 2001  
Supersedes TN New Effective Date OCT 01 2000

General

- a) Prior approval of the local professional director shall be required for medical care and services which are to be provided outside New York State, except in the following situations:
  - 1. When it is customary for the inhabitants of the district generally to use medical care resources and facilities outside New York State.
  - 2. When out-of-state care was provided in an emergency.
- b) When a request subject to prior approval has been modified or denied in whole or in part because of disagreement with the proposed plan of treatment, recipients are notified that they may request a fair hearing.

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 Effective date OCT. 1 1985

TN No. 85-30  
 Supersedes  
 TN No. 82-11

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Page 5

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Supplement  
(04/05)

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES  
PROVIDED TO THE CATEGORICALLY NEEDY

In addition to the limitations specified on pages 1 through 4 regarding services,  
the following limitations also apply to the noted services:

2a.; 2b.; 2c.; 2d.;

Services will be provided in accordance with the utilization threshold requirements described in departmental regulations, which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

3. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations, which are based on medical necessity and identified for providers in the MMIS Laboratory Provider Manual. Such threshold requirements are applicable to specific provider service types including laboratories. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.
5. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations, which are based on medical necessity and identified for providers in the MMIS Physician Provider Manual. Such threshold requirements are applicable to specific provider service types including physicians, for services furnished in the office or patient's home. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

TN#:           #05-26                Approval Date:           MAR 18 2010            
Supersedes TN#:           #93-53                Effective Date:           APR 01 2005

**OFFICIAL**

A utilization threshold service is decremented each time a patient is seen by a physician including those times when the patient is seen by a physician and an electronic prescription/fiscal order is transmitted for medically necessary pharmaceuticals and select over the counter medications.

TN #09-53 \_\_\_\_\_

Approval Date APR 08 2010

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(10/06)**

9. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.
- 11a. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provisions of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.
- 11b. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess or prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

TN #06-61 \_\_\_\_\_

Approval Date JUN 10 2010

Supersedes TN #93-53 \_\_\_\_\_

Effective Date JAN 01 2007

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(10/06)**

- 11c. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.
- 12a. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Pharmacy Provider Manual. Such threshold requirements are applicable to specific provider service types including pharmacy for prescription items and their refills, over the counter medications, and medical/surgical supplies dispensed by a community or outpatient pharmacy. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

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Approval Date JUN 10 2010

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Effective Date JAN 01 2007

# OFFICIAL

Revision: HCFA-PN-87-4

March 1987

Supplement 1 to Attachment 3.1A

Page 1 -A1

OMB No.: 0939-0193

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

### CASE MANAGEMENT SERVICES

- A. Target Group: A
- B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

The counties of Albany, Allegany, Cattaraugus, Cayuga, Chemung, Columbia, Cortland, Dutchess, Franklin, Fulton, Genesee, Herkimer, Jefferson, Livingston, Madison, Monroe (zip codes 14605, 14621, and 14609), Onondaga, Orange, Orleans, Rensselaer, St. Lawrence, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Suffolk, Sullivan, Tompkins, Ulster, Washington, Westchester, Wyoming, Yates, and New York City (Bronx Commun. Dist. 1-4, Brooklyn Commun. Dist. 5, 8, 9, 16-18, Manhattan Commun. Dist. 9-12, Queens Commun. Dist. 3, 4, 6, 7, 8, 11-13, and Richmond Commun. Dist. 1-3)

- C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

- D. Definition of Services:

See attached.

- E. Qualification of Providers:

See Page 1-A10.

TN No. 04-08

Supersedes

TN No. 01-30

95-47

Approval Date OCT 04 2004

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Revision: HCFA-PN-87-4  
March 1987

Supplement 1 to Attachment 3.1A  
Page 1 - A1a  
OMB No.: 0939-0193

State/Territory: New York State

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TN No. 04-08

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TN No. 95-47

88-5

OCT 04 2004

Approval Date \_\_\_\_\_

Effective Date ~~JAN 01 2004~~

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A. TARGET GROUP

The primary targeted group consists of any adolescent, male or female, under 21 years of age who is a categorically needy or medically needy Medicaid eligible and is a parent and resides in the same household with his or her child(ren), or is pregnant.

The target group may also consist of any eligible child of an adolescent or any adolescent, male or female under 21 years of age, who is a categorically needy or medically needy Medicaid eligible and is deemed to be at risk of pregnancy or parenthood and meets one or more of the following at-risk criteria:

- 1) receives public assistance in his or her own right;
- 2) is homeless or at imminent risk of becoming homeless;
- 3) has had an abortion or miscarriage
- 4) has had a pregnancy test, even if the test outcome was negative;
- 5) is sexually active;
- 6) is the non-custodial mother or father of a child;
- 7) is the younger sibling of an individual who was or is a teenage parent;
- 8) is a rape or incest victim;
- 9) has dropped out of high school without graduating;
- 10) is having academic and/or disciplinary problems in school;
- 11) requests case management activities, or his or her authorized representative requests such activities on behalf of the adolescent; or
- 12) is the child of adolescent parent(s).

Sixty percent of the current ADC cases in New York State are headed by mothers who were teenagers when they gave birth to their first child. The goal of case management for this target population is to provide access for youth to medical, educational, employment and other services which will increase their potential to become financially independent. Case management services continue for this target population through age 21.

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**B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP A**

Case management services will be provided to residents of the following counties: Albany, Allegany, Cattaraugus, Cayuga, Chemung, Columbia, Cortland, Dutchess, Franklin, Fulton, Genesee, Herkimer, Jefferson, Livingston, Madison, Monroe (zip codes 14605, 14621, and 14609), Onondaga, Orange, Orleans, Rensselaer, St. Lawrence, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Suffolk, Sullivan, Tompkins, Ulster, Washington, Westchester, Wyoming, Yates and New York City (Bronx Commun. Dist. 1-4, Brooklyn Commun. Dist. 5, 8, 9, 16-18, Manhattan Commun. Dist. 9-12, Queens Commun. Dist. 3, 4, 6, 7, 8, 11-13, and Richmond Commun. Dist. 1-3)

**D. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID**

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

**BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT**

1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychological, educational, financial, and other services.
2. Case management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service, or having problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective management is concerned with service: the quality, adequacy and continuity of service, and a concern for cost effectiveness to assure each eligible individual served receives the services appropriate to their needs. Targeted groups consist of persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human services providers.

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95-47

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3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing knowledge of services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in their most appropriate environment. Case managers do not have the authority to prior authorize Medicaid services, or to limit the amount, duration or scope of Medicaid services.
  
4. Case management empowers the individual by encouragement in the decision making process, allowing choice among all available options as a means of moving the individual to the optimum situation where the person and/or his/her support system can address his/her needs. Case management implies utilization and development of such support networks as will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

#### DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP A

Case management for Target Group A means those activities performed by case management staff, in consultation with an adolescent parent of an eligible child or with a eligible adolescent and other individuals involved with the child or adolescent if appropriate, related to ensuring that the adolescent and child have full access to the comprehensive array of services and assistance available in the community which the adolescent needs to maintain and strengthen family life and to attain or retain capability for maximum self support and personal independence.

Case management for Target Group A requires referral to and coordination with medical, social, educational, psycho-social, employment, habilitation, rehabilitation, financial, environmental, legal and child care services available within the community appropriate to the needs of the adolescent.

#### CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient's circumstances and therefore must be determined specifically in each case and with each recipient's involvement. A separate case record must be established for each individual recipient of case management services and must document each case management function provided, including:

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Supersedes TN 88-5 Effective Date JAN 31 1990

- A. **Intake and screening.** This function consists of: the initial contact with the recipient providing information concerning case management; exploring the recipient's interest in the case management process; determining that the recipient is a member of the provider's targeted population; and, identifying potential payors for services.
- B. **Assessment and reassessment.** The case manager must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and, a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.
- C. **Case Management plan and coordination.** The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, duration and cost of the case management services required by a particular recipient; selection of the nature, amount, type, frequency and duration of services to be provided to the recipient with the participation of the recipient, the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers, through case conferences to encourage exchange of clinical information and to assure:
1. the integration of clinical care plans throughout the case management process;
  2. the continuity of service;
  3. the avoidance of duplication of service (including case management services); and,

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Supersedes TN 7000

Effective Date JUN 11 1994

Effective Date JAN 01 1994

4. the establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational, and financial needs of the recipient.
- D. **Implementation of the case management plan** includes: securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.
- E. **Crisis intervention** by a case manager or practitioner when necessary, includes: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.
- F. **Monitoring and follow-up** of case management services includes: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring that the recipient is adhering to the case management plan; ascertaining the recipient's satisfaction with the services provided and advising the preparer of the case management plan of the findings if the plan has been formulated by a practitioner; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.
- G. **Counseling and exit planning** include: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of services; mediating among the recipient, the family network and/or other informal providers of services when problems with

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Supersedes TN NEW

Revised Date: JAN 01 1988

service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

**PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE**

1. **Assessments.** The case management process must be initiated by the recipient and case manager through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes those activities listed in paragraph B of **CASE MANAGEMENT FUNCTIONS**.

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An updated assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. **Case management plan.** A written case management plan must be completed by the case manager for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include those activities outlined in paragraph C under **CASE MANAGEMENT FUNCTIONS**.

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The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan; and each time the case management plan is reviewed, the goals established in the initial case management plan must be maintained or revised, and new goals and new time-frames may be established with the participation of the recipient.

The case management plan must specify:

- a. those activities which the recipient is expected to undertake within a given period of time toward the accomplishment of each case management goal;
  - b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
  - c. the type of treatment program or service providers to which the recipient will be referred.
  - d. the method of provision and those activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and
  - e. the type, amount, frequency, duration and cost of case management and other services to be delivered or tasks to be performed.
3. **Continuity of service.** Case management services must be ongoing from the time the recipient is accepted by the case management agent for services to the time when: the coordination of services provided through case management is not required or is no longer required by the recipient; the recipient moves from the social services district to a district in which case management services are not provided; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services; or, the recipient's case is appropriately transferred to another case manager.

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Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with New York State Department of Social Services.

### LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

#### Case management services:

1. must not be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s) including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. must not duplicate case management services currently provided under the Medical Assistance Program or under any other program;
3. must not be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority; and.
4. must not be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a Federal Home and Community Based Services Waiver.

While the activities of case management services secure access to, including referral to and arrangement for, an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;

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3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, SNF's, ICF's and ICF/MR's; and
9. client outreach.

**LIMITATIONS SPECIFIC TO TARGET GROUP A**

Case managers and case management staff with respect to any eligible child of an adolescent or adolescent in Target Group A for whom case management activities are being performed and the child(ren) of such adolescent, are prohibited from and do not have the authority to:

1. provide, authorize or purchase services or assistance reimbursable under Title XX of the federal Social Security Act or otherwise administered or funded by the social services district;
2. accept or deny any application for public assistance or for services or assistance reimbursable under Title XX of the federal Social Security Act or otherwise administered or funded by the social service district; or,
3. place the adolescent or his or her child(ren) in foster care, or remove the adolescent or his or her child(ren) from the home of his or her parent or guardian.

**E. QUALIFICATIONS OF PROVIDERS**

1. Providers

Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services who are approved by the New York State Commissioner of Social Services based upon an approved proposal submitted to the New York State Department of Social Services. Providers may include:

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- a. facilities licensed or certified under New York State law or regulation;
- b. health care or social work professionals licensed or certified in accordance with New York State law;
- c. State and local governmental agencies; and
- d. home health agencies certified under New York State law.

2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under **CASE MANAGEMENT FUNCTIONS**, including the performance of assessments and development of care management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

- a. one year of case management experience and a degree in a health or human services field; or
- b. one year of case management experience and an additional year of experience in other activities with the target population; or
- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under **CASE MANAGEMENT FUNCTIONS**, including the performance of assessments and development of case management plans; or
- d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. Qualifications of Providers Specific to Target Group A\*

1. Providers

Providers of case management to the adolescents in Target Group A may be public or private agencies and organizations, whether operated on a profit-making or not-for-profit basis.

2. Case Managers

Case managers must have the education, experience, training and/or knowledge in the areas necessary to assess the needs and capabilities of, and to assist pregnant, parenting or at-risk adolescents access to services and assistance needed to maintain and strengthen

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family life, to attain or retain the capability for maximum self support and personal independence including, but not limited to the areas of adolescent development, adolescent sexuality, and effective interviewing techniques.

Primary responsibility for performing case management activities must be given to case managers. Para-professional and volunteers may be used as case management staff to assist the case managers and may perform those activities which are appropriate based on their training and experience.

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\* (18 NYCRR 361.0-361.13 NYS DSS Regulatory requirements for implementation of the New York State Teenage Services Act of 1984.)

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

## CASE MANAGEMENT SERVICES

## A. Target Group:

See attached Target Group B

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## B. Areas of State in which services will be provided:

 Entire State. Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

## C. Comparability of Services

 Services are provided in accordance with section 1902(a)(10)(B) of the Act. Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

## D. Definition of Services:

See attached

## E. Qualification of Providers:

See attached

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OMB No.: 0939-0193

State/Territory: New York State

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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HCFA ID: 1040P/0016P

**NEW YORK STATE  
CASE MANAGEMENT SERVICES**

**A. TARGET GROUP B**

Persons enrolled in Medical Assistance who:

- (1) Have a documented diagnosis of mental retardation or a developmental disability as defined in New York Mental Hygiene Law §1.03, and
- (2) Are in need of ongoing and comprehensive service coordination rather than incidental service coordination, and
- (3) Have chosen to receive the services, and
- (4) Do not reside in intermediate care facilities for the developmentally disabled; State operated Developmental Centers; Small Residential Unit (SRU); Nursing Facilities, or hospitals or any other medical assistance institutional settings that provide service coordination, and
- (5) Are not concurrently enrolled in any other comprehensive service coordination service funded under Medical Assistance.

**B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET**

Entire State

**C. DEFINITION OF MEDICAID SERVICE COORDINATION TO TARGET GROUP B**

Medicaid Service Coordination (MSC) for Target Group B is a service which assists persons with developmental disabilities in gaining access to necessary services and supports appropriate to the needs of the individual. MSC is provided by qualified service coordinators and uses a person-centered approach to planning, developing, maintaining, and monitoring an Individualized Service Plan (ISP) with and for a person with developmental disabilities. MSC promotes the concepts of choice, individualized services and supports and consumer satisfaction.

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**D. Medicaid Service Coordination Functions**

General Service Description

Medicaid Service Coordination helps a person access necessary supports and services including medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, residential and legal services available and in accordance with the person's valued outcomes as expressed in the Individualized Service Plan (ISP).

Medicaid Service coordination functions are:

- Enrollment ("intake")
- Development of the Individualized Service Plan (ISP)
- Implementation of the ISP
- Maintenance of the ISP

Enrollment

The service coordinator assesses eligibility for MSC based on the criteria specified in A above. The service coordinator completes necessary enrollment documents.

Development of the Individualized Service Plan (ISP)

The Individualized Service Plan (ISP) is developed using a person-centered approach. The service coordinator helps the person plan by choosing personal valued outcomes, and developing a personal network of activities, supports and services. The plan identifies those supports and services chosen by the consumer with the service coordinator's assistance, as well as the entities that will supply them. The resulting planning information is written in the appropriate ISP format.

ISP development also includes the execution of a Service Coordination Agreement. This agreement, between the person served and the service coordinator, describes the service coordination activities the person wants and needs to meet his or her individualized goals as described in the ISP.

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Implementation of the Individualized Service Plan (ISP)

Using the ISP as a blueprint, the service coordinator works with the person to achieve his or her valued outcomes. Chosen activities, supports, and the full array of services are accessed as identified in the plan. The service coordinator uses knowledge of the community and available resources and employs specialized skills to successfully implement the ISP. The service coordinator:

- Locates or creates natural supports and community resources.
- Locates funded services, helps determine eligibility, completes referrals, facilitates visits and interviews.
- Helps arrange for transportation to the community activities and services as necessary.
- Assists in communicating the content of the ISP, including valued outcomes, to service providers and assists providers in designing and implementing services consistent with the ISP.

Maintenance of the ISP

This is the ongoing service provided by the service coordinator. It includes:

- Assessing the person's satisfaction with his or her ISP, including the Service Coordination Agreement, and making adjustments as necessary.
- Supporting the person towards achievement of valued outcomes.
- Establishing and maintaining an effective communication network with service providers.
- Keeping up to date with changes, choices, temporary setbacks and accomplishments relating to the ISP
- Managing through difficulties or problems or crises as they occur.
- Assisting the consumer in assuring that rights, protections and health and safety needs are met pursuant to state law and regulations.
- Keeping the ISP document, including the Service Coordination Agreement, current by adapting it to change.
- Reviewing the ISP at least semi-annually.

TN 00-07 Approval Date JAN 10 2001  
Supersedes TN 89-16 Date MAR 01 2000

Systemic Features and Functions

OMRDD centrally and through its local DDSOs will:

- Ensure access to the service for all eligible people.
- Assist people served in choosing a service coordination provider by making the full range of provider options known to the person and his/her family.
- Match individual needs of people with special provider capabilities and characteristics.
- Ensure uniformity in service coordinator and service coordinator supervisor basic training.
- Provide standardized curricula for service coordinators' ongoing training.
- Organize and schedule training and carry out training.
- Carry out functions necessary to ensure quality of service and proper management of the program.
- Monitor Service Coordination Agreements between the service coordinator and the person served to ensure service coordinator fulfillment of commitments according to the agreed upon time frame.
- Make referrals to other service coordination providers when a person is dissatisfied with the current service provider.
- Monitor complaints of persons served and their families to detect patterns of poor service quality.
- Require provider corrective action as necessary.
- Oversee provider terminations and necessary referrals to other service coordination providers as necessary.

**E. LIMITATIONS ON THE PROVISION OF MEDICAID SERVICE COORDINATION**

Medicaid service coordination will not:

1. Be utilized to restrict the choice of a service coordination consumer to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis.
2. Duplicate case management services currently provided under the Medical Assistance Program or under any other program.

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December 16, 1999

3. Be utilized by providers of service coordination to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority and
4. Be provided to persons receiving institutional care reimbursed under the Medical Assistance Program, except that Medicaid service coordination may be provided for up to 30 days to persons who are temporarily institutionalized, when the admission to the institution is initially expected to be 30 days or less.

While the activities of Medicaid Service Coordination secure access to an individual's needed service, the activities of service coordination do not include:

1. The actual provision of the service;
2. Medicaid eligibility determinations/redetermination;
3. Medicaid pre-admission screening;
4. Prior authorization for Medicaid services;
5. Required Medicaid utilization review;
6. EPSDT administration;
7. Activities in connection with "lock-in" provisions under §1915(a) of the Social Security Act;
8. Institutional discharge planning as required of hospitals, SNF's, and ICFs/MR and
9. Client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

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**F. QUALIFICATIONS**

1. Providers

Pursuant to §1915 (g)(1) of the Social Security Act, Medicaid service coordination will be provided by New York State OMRDD through a network of OMRDD employees and contractors.

2. Service Coordinators

Service coordinators must:

(a) either;

(1) have experience providing OMRDD Comprehensive Medicaid Case Management (CMCM) or OMRDD Home and Community Based (HCBS) Waiver Service coordination or

(2) (i) be a registered nurse or have at least an associate's degree (or equivalent accredited college credit hours) in a health or human services field, and

(ii) have at least one year's experience working with persons with developmental disabilities or at least one year's experience providing service coordination to any population, and

(b) attend professional development courses required by OMRDD.

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**G. METHOD OF REIMBURSEMENT**

The method of reimbursement shall be a monthly fee established by OMRDD in conjunction with the New York State Department of Health and approved by the New York State Division of the Budget.

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2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of care management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

- a. one year of case management experience and a degree in a health or human services field; or
- b. one year of case management experience and an additional year of experience in other activities with the target population; or
- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans; or
- d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. Qualifications of Providers Specific to Target Group "B"

1. Providers

Providers of Comprehensive Medicaid Case Management to developmentally disabled persons in Target Group "B" shall only be the Borough/District Developmental Services Offices (B/DDSO) of OMRDD and voluntary non-profit agencies and organizations authorized by OMRDD as CMC/OMRDD providers, and identified by OMRDD to SDSS.

2. Case Managers

Case managers serving Target Group "B" must meet the minimum qualifications described above.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

CASE MANAGEMENT SERVICES

A. Target Group:

See attached Target Group C

90-42

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

TS No. 90-42

Supersedes

TS No. **New**

Approval Date OCT 10 1991

Effective Date JUL - 1 1991

should follow C1 (replaced C1a)  
Supp to Att 3.1A

Revision: HCFA-PM-87-4 (BERG)  
MARCH 1987

SUPPLEMENT 1 TO ATTACHMENT 3.1-A  
Page 2  
OMB No.: 0939-0193

State/Territory: New York State

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
  - 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

90-42

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TM No. 90-42      Approval Date OCT 10 1991      Effective Date JUL - 1 1990  
 Supersedes  
 TM No. 89-17      HCFA ID: 1040P/0016P

State/Territory: New York State

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TM No. 90-42  
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TM No. **New**

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HCFA ID: 1040P/0016P

## A. Target Group C

This target group consists of any categorically needy or medically needy individual who meets one or more of the following criteria:

1. All HIV infected persons;
2. All HIV antibody positive infants up to age 3 years if seroconversion has not been firmly established; and
3. All high risk individuals for a temporary period of time not to exceed 6 months with transition to another appropriate case management program for individuals who are HIV negative or continued unknown status. High risk individuals as the term is used in the expanded target Group C AIDS CMCM population are those individuals who are members of the following category:

Men who have sex with men (MSM), substance abusers, persons with history of sexually transmitted diseases, sex workers, bisexual individuals, sexually active adolescents engaging in unprotected sex, and persons who engage in unprotected sex with HIV+ or high risk individuals.

Family members and coresidents (ie. collaterals) of the above targeted index clients may also receive case management services as necessary, to allow for the provision of necessary care and services to the targeted individual. Services for case collaterals shall be considered as one family unit in the case manager's caseload. Separate assessments and service plans are not required for collaterals, but may be incorporated into the case records of the primary client. Collaterals may have services arranged for by the case management provider. Case management services for collaterals should be limited to issues that directly affect the care of and services to the primary client.

The clients targeted under this proposal face enormous barriers to care, such as continuing drug and alcohol use, and their associated medical and social problems, domestic violence, mistrust of medical care and other services, fear of losing their children to foster care, fear of HIV infection and its consequences, lack of transportation and day care services, and lack of support in accessing care for their sexual partner and/or coresidents. These barriers to care can be overcome by the persistent efforts of indigenous community follow-up workers in cooperation with case managers. These workers must have special skills and strengths to deal with these problems, to win the trust and confidence of their clients in order to motivate them to return to care and to be continuously monitored thereafter. The magnitude of the effort required to accomplish this exceeds the capabilities of existing institutional bound and community case managers and requires the extensive frequent personal contact possible through an intensive case management program under Comprehensive Medicaid Case Management.

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Supersedes TN 011-09 Effective Date 11-1-1994

B. AREAS OF THE STATE WHERE SERVICES MAY BE PROVIDED

90-42

Services to this target group may be provided statewide.

C. COMPARABILITY OF SERVICES

Services will only be provided to those individuals who meet one or more of the criteria set forth in Section A, Target Group, of this Supplement.

Case management services will be provided without limitation as to amount, duration or scope.

D. DEFINITION OF CASE MANAGEMENT UNDER THE COMMUNITY FOLLOW-UP PROGRAM (CFP)

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

Case management is a multi-step process comprised of the following activities:

1. Intake
2. Assessment
3. Initial Care Plan Development
4. Initial Care Plan Implementation
5. Reassessment
6. Care Plan Update
7. Care Plan Update Implementation
8. Monitoring
9. Crisis Intervention Activities
10. Termination/Case Disposition Activities
11. Client Advocacy, Interagency Coordination and Systems Development Activities
12. Supervisory Review/Case Conferencing

The sections below describe the specific functions in detail.

1. Intake

The case manager should collect identifying information concerning the client, family, care givers and informal supports including the intake elements required on forms developed or approved by the State Department of Health. A list of family members, coresidents and children not currently living at home should be recorded including identification of the primary caregiver, primary contacts and legal guardian(s) of the child(ren). Client consent to case management, including home visitation, case conferencing, service acquisition and registration procedures, should be obtained and documented in the case records.

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Intake procedures should be initiated upon referral to the Community Follow-up Program provider and completed after the first visit. The Intake procedures may be completed by the case manager, technician or the community follow-up worker. The intake includes confirmation that the case management program has been fully explained to the client. Clients have the right to choose care providers and, therefore, may choose whether or not to enroll in the case management program.

## 2. Assessment

Assessment is the collection of information about the client's medical, physical and psychosocial condition, resources, needs, and confirmation of eligibility for the program. The assessment process should include a home visit to evaluate the client's needs, informal supports, and general living conditions. All family members should be seen in the assessment interview(s), if possible. Direct caregivers and family members not able to be interviewed should be contacted by phone, if possible. The purpose of assessment is to identify the client's/family's problems and care needs, what care needs are being met and by whom, and what needs are not adequately met. The initial assessment will focus on immediate health and social services needs and address the client's history of underutilization of care, and the reasons for such underutilization. Assessments will be documented on forms required or approved by the State Department of Health, AIDS Institute.

Assessment activities should be completed following the second visit but no later than 15 days from the date of receipt of the referral. The assessment should be completed by the case manager with assistance from the case management technician.

## 3. Initial Service Plan Development

Development of the service plan is the translation of assessment information into specific goals and objectives, and specific services, providers and timeframes to reach each objective. The service plan is developed by the case manager, in coordination with the client, representative and other providers.

The service plan will reflect goals and services to be provided to the client and family members. If services actually provided differ, a note explaining the difference should be made. The costs and sources of payment for all services should be documented as required by Department of Social Services regulations 505.16. The client's response to the final plan, consent to case management and/or declination of any part of the plan by the client should be documented on forms approved by the Department of Health.

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Supersedes New Effective Date III - 1 1990

It is the intent of New York State that case management in the Community Follow-up Program represent a fully integrated case management approach. The case manager coordinates all necessary services along the continuum of care - both institutional and community based by both directly accessing services and by establishing linkages with other service programs including those under the jurisdiction of the local department of social services. The role of the case manager is to reduce the barriers in crossing administrative boundaries to ensure that clients obtain needed services at the appropriate time from wherever the services are available. Services accessed for the client should include institutional and non-institutional medical and non-medical services, social and other support services and linkages to existing community resources. In so doing, the case manager will access and coordinate services with other case managers who may also serve the client. The service plan will be developed following the second client contact. Immediate needs should be addressed by the case manager and such services should be implemented immediately after the intake. Other assessed needs should be addressed as soon as possible but in no case later than 30 days from the date of receipt of the referral. The service plan is to be developed by the case manager with the assistance of the technician or community follow-up worker.

#### 4. Initial Service Plan Implementation

In implementation of the service plan, or service acquisition, the case manager assists the client and family or coresidents as needed, in contacting the support persons and other service providers to negotiate the delivery of planned services. The service plan may be modified to accommodate the client, family members, coresidents, support persons, and service providers. Any changes from the original plan should be noted in the record. These activities may be accomplished by the case manager or a member of the case management team.

The case manager, case management technician or community follow-up worker will (in accordance with the client's assessed abilities):

- a. contact providers, including support persons, by phone, in writing or in person
- b. assist the client and family members or coresidents in making applications for services and entitlements, including basic needs such as transportation, child care, baby-sitting, etc.
- c. confirm service delivery dates with providers, and supports
- d. schedule multiple visits by family members on the same day to accommodate the needs of the family and children
- e. document services that aren't available or cannot be accessed

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- f. gain assurance from other care providers that services will be initiated, and confirm the delivery of these services
- g. decide, with the client and other providers, on the ongoing responsibilities of each provider
- h. give other service providers accurate and complete information about the service(s) they are expected to provide and the services provided by others.

Any changes to the service plan due to scheduling or availability of services will be documented. Service plan implementation should begin immediately after service needs are assessed and is an ongoing responsibility of the case manager. The case manager and support staff, in accordance with the client's assessed abilities, will assist the client by contacting providers and support persons when needs are identified. Assistance continues until the case manager or staff determines that the services have been arranged and received. Confirmation of need for, application for and receipt of services is required.

5. Reassessment

Reassessment is a scheduled or event generated formal re-examination of the client's situation, functioning, clinical and psychosocial needs, to identify changes which have occurred since the initial or most recent assessment. The reassessment should measure progress toward the desired goals outlined in the care plan and is used to prepare a new or revised service plan or confirm that current services remain appropriate. Reassessment is the responsibility of the case manager.

A formal reassessment under the program for clients who are receiving intensive case management is due within 90 days of admission and every 90 days thereafter or when a change in the client's status occurs which significantly effects the service plan. Significant changes in status include:

- a. death, illness or hospitalization of a family member or care giver(s), or a condition or circumstance which impairs the client's ability to provide for the family's physical and/or emotional needs,
- b. change in the client's clinical or functioning status,
- c. loss of domicile, entitlement, or service.

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6. Service Plan Update

Updating the service plan means modification to or revision of the service plan based on reassessment. Update of the service plan may also occur as a result of changes in clients' needs, or information from monitoring contacts when changes are not significant as to require a formal reassessment. Update of the service plan includes all activities of service plan development, described above in subsection c, relative to new or changed needs and services. The service plan should be updated at every reassessment or when a change in client status occurs which significantly affects the service plan. The service plan may be updated by the case manager with assistance from the members of the case management team.

7. Service Plan Update Implementation

Implementation of the updated service plan includes the same activities as described for service plan implementation noted in subsection d, and may be the responsibility of the technician or community follow-up worker under the supervision of a case manager.

8. Monitoring

Monitoring is contact between the case manager or support staff and the client or representative. Support persons and service providers will also be contacted if necessary. The purpose of these contacts is to assure that services are being delivered according to the service plan. Contacts may include encounters in the agency, home, hospital or outpatient department, contacts by phone or in person. Any problems noted during monitoring contacts will be followed up immediately with the client, support person or provider, as needed, to address the problem.

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The case manager and case management team will also coordinate the medical monitoring of all persons who are HIV positive with the primary care physician, clinic or AIDS Center responsible for the medical monitoring of asymptomatic HIV disease. This service includes the ongoing monitoring of preclinical HIV infection (asymptomatic) to determine the appropriate stage to initiate active prophylactic and secondary treatment for opportunistic infections. This service applies to HIV positive persons prior to clinical manifestations or laboratory evidence of HIV illness. The case manager should assure that CD4 ((T4)) testing is done every three or six months as appropriate, and if symptoms of HIV illness are identified, therapies provided by a referral to an AIDS Center hospital or appropriate outpatient department be arranged. Periodic testing for persons at risk, when requested, or when high risk behavior is reported or suspected should also be arranged by the case manager and case management team.

For clients receiving intensive case management in the Community Follow-up Program, a minimum of 9 contacts is required every 90 days. A minimum of six of these contacts must be face to face with the client. A minimum of four of these contacts must be home visits. Greater frequency of contacts in all categories will be arranged on an as needed basis and are in fact encouraged and anticipated in an intensive case management program. The case manager must personally have two contacts with the primary client every 90 days. Case conferences will be held for families with multiagency service plans including agencies such as Certified Home Health Agencies, local child welfare or community based organizations. Conferences will take place within 90 days of initial care plan implementation and every 180 days thereafter.

9. Crisis Intervention

The purpose of crisis service is to provide assessment and intensive short term treatment of acute medical, social, physical or emotional distress. Crisis intervention should be made available to all Community Follow-up Program clients on an emergency 24 hour basis through subcontract with a 24 hour crisis agency, or via direct provision by the case manager, by a crisis hotline, use of mobile crisis teams, or through referral to the Community Follow-up Program Director or supervisor. Crisis services may be needed for a variety of reasons. The crisis may relate to an emergency medical need, drug use or drug overdose, domestic violence or child abuse, etc. Irrespective of the nature of the crisis, it is the responsibility of the case manager or provider agency to assist the client, family, coresident or lover in obtaining the appropriate response to the situation, keeping in mind the need to maintain the client's dignity and rights to privacy and confidentiality. In addition, the crisis intervention should be designed to decrease inappropriate utilization of emergency rooms by targeting the response more appropriately to the identified crisis.

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10. Exit Planning/Case Discontinuations

Exit planning procedures are initiated when the client:

- a. expires
- b. loses Medicaid or programmatic eligibility, though Medicaid eligibility is not required for eligibility in the CFP, or
- c. declines the case management services of CFP, or
- d. desires to be referred to a different CFP provider agency or to an existing case management program such as the Long Term Home Health Care Program, AIDS Home Care Program, or
- e. will be institutionalized for greater than 30 days if Medicaid is the payor for such hospitalization and discharge to community based care is not anticipated. For private pay and third party individuals, case management services may continue beyond the 30 day limit while hospitalized, or
- f. the client relocates out of the CFP providers' service area.

In all cases, except where the client expires, the provider must complete a referral process designed to link the client with appropriate ongoing case management and other vital services necessary to meet their care needs. The provider must refer the client to another eligible CFP provider if one exists within the geographic area in which the client resides. With the client's consent, a case summary should be prepared for referral to the new provider. A final assessment noting disposition and measures of progress toward identified goals should be prepared and placed in the final record. The local Department of Social Services should be notified of the case disposition and can assist in referral of the client to alternate case management providers. Exit planning is a responsibility of the case manager with assistance from the members of the case management team.

11. Patient Advocacy, Interagency Coordination and Systems Development

The function of the case manager is to be an advocate for services for the client with particular emphasis on self-sufficiency in the community and avoidance of premature or unnecessary institutionalization.

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12. Supervisory Review/Case Conferencing

An important component of the required quality assurance process for each CFP provider will be supervisory review of case management documentation, care plans and other products as well as peer review or case conferencing with other case managers. Therefore, for clients receiving case management, supervisory review of each client care plan by the designated supervisor or agency director will be conducted initially at the time of the development of the original service plan and every 90 days thereafter. In addition, each agency participating as a CFP provider will establish a peer review process wherein all case managers will present and discuss client specific case management plans with other case managers in the agency at least once annually. While we are requiring the supervisory function, we are not requiring a supervisory role. In this way agencies will have the flexibility to provide supervision with either in house staff or through an outside consultant.

Case managers will also be required to case conference with other agencies regarding specific clients at 90 days after service plan implementation and every 180 days thereafter, taking into consideration client consent, the client's need for confidentiality and privacy, as well as Department of Health Regulations on confidentiality. This would include contacts with discharge planners, case managers from other agencies, etc. Supervisory review and case conferencing are billable on a direct patient specific basis in the community Follow-up Program. Agency conferences that are not patient specific are not directly billable; however, projected costs for these activities may be included in the administrative budget submitted by each provider.

13. Program Limitations

Case Management under the Community Follow-up Program:

1. must not be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program that is qualified to provide such care or services and who undertakes to provide such care or service(s) including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. must not duplicate certain case management services currently provided under the Medical Assistance Program or other funding sources such as the Long Term Home Health Care Program, AIDS, Home Care Program under Chapter 622 of the Laws of 1988, and the Care at Home Program (Katie Beckett Model Waivers).

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3. must not be utilized by providers of case management to create a demand for unnecessary services or programs, particularly those services or programs within their scope of authority; and
4. must not be provided to persons receiving institutional care for more than 30 days or when discharge to community based care is not anticipated and care is reimbursed under the Medical Assistance Program. Case management services may be provided for children and family members during this period of hospitalization.

While the activities of case management services secure access to, including referrals to and arrangements for, an individual's needed service, reimbursement for case management does not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. administration of Child-Teen Health Program Services;
7. activities in connection with "lock-in" provisions under 1915(a) of the social Security Act;
8. institutional discharge planning as required of hospitals, SNFs, ICFs and ICF/MRs; and
9. client outreach.

#### E. QUALIFICATIONS

##### 1. Provider Qualifications

Provider agencies applying for participation in the Community Follow-up Program must meet one of the following requirements:

- (a) have 2 years demonstrated experience in the care of the clients with HIV related illnesses or in providing case management or other services to clients with HIV illness. Examples of eligible agencies will include: Article 28 facilities, Community Based Organizations (CBOs), Community Health Centers (CHCs), or Community Service Programs (CSPs), Certified Home Health Agencies (CHHAs), or
- (b) have 3 years demonstrated experience in the provision of maternal/pediatric services or in providing case management or care planning services to prenatal or post partum women and their children or families, or

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- (c) have 3 years demonstrated experience in the provision of drug abuse and/or drug treatment services, foster care preventive services or adult protective services including case management to clients and families that are at risk of foster care, including but not limited to local departments of social services, or
- (d) be a hospital that has a provider agreement with the New York State Department of Health to participate in the Department's Obstetrical HIV Counseling/Testing/Care Initiative.

## 2. Staff Qualifications

### A. Case Manager Qualifications

To be eligible for reimbursement under this program, the case manager employed by the agency must meet the following required education/experience:

1. a Bachelor's or Master's Degree which includes a practicum encompassing case management practices or a major in Psychology, Sociology, Social Work, or related subjects, or
2. one year of qualified experience and an Associate Degree or 60 credit hours of college study from a regionally accredited college or university or one recognized by the New York State Education Department as following acceptable educational practices, or
3. two years of qualified experience and/or of case management experience, or
4. a degree in nursing or certification as a registered professional nurse or a licensed practical nurse with one year of qualified experience, or
5. qualifications meeting the regulatory requirements of a state agency for case manager.

Qualified Experience means verifiable full, part time or voluntary case management or case work with the following target populations:

1. persons with HIV related illnesses
2. women, children and families at risk of foster care
3. substance using families

### B. Case Management Technician Qualifications

Case management technicians must have a high school diploma or equivalent or must be working towards a high school equivalency diploma (GED) at the time of employment, have one year of qualified experience and have received intensive training in the Case Management Technician curriculum developed by Hunter College, and shall work under the supervision of the case manager.

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Supervisor New Effective Date JUL -1 1990

C. Community Follow-up Worker Qualifications

90-42

The community follow-up worker, under the supervision of the case manager or case management technician, has no required educational or experiential requirements, but should have the following characteristics:

- a. maturity, emotional and mental stability
- b. ability to read and write, understand and carry out directions and instructions, record messages and keep simple records
- c. be a resident or at least familiar with the local community and have knowledge of services and resources that are available
- d. good physical health
- e. a sympathetic attitude towards providing services to persons with HIV illness
- f. fluency in local languages such as Spanish and Creole
- g. experience working in the community preferable

In addition, the agency shall have the responsibility of assuring that all case managers, technicians and community follow-up workers employed (including volunteers) receive a 2-3 day orientation training within the first month of employment in the agency. Each agency must maintain a training log to document the provision of training to all employees.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT 89 17

State/Territory: New York State

**CASE MANAGEMENT SERVICES**

**A. Target Group:**

See attached Target Group "D"

**B. Areas of State in which services will be provided:**

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

**C. Comparability of Services**

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

**D. Definition of Services:**

See attached

**E. Qualification of Providers:**

See attached

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March 1987

OMB No.: 0939-0193

State/Territory: New York State

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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HCFA ID: 1040P/0016P

A. TARGET GROUP D

The targeted group consists of medical assistance eligibles who are served by the Office of Mental Health's Intensive Case Management Program and who:

- (i) are seriously and persistently (chronically) mentally ill and
- (ii) require intensive, personal and proactive intervention to help them obtain services, which will permit or enhance functioning in the community and
- (iii) either have symptomology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

These individuals include:

- (1) high risk/heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. May have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities;
- (2) extended care state psychiatric center patients who could be discharged but are not because of the absence of needed support in the community;
- (3) mentally ill who are homeless and live on the streets or in shelters;
- (4) seriously mentally ill children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and may, without intervention, be institutionalized, incarcerated or hospitalized.

The aim is to benefit these clients by reducing hospitalization and reliance on emergency psychiatric services, as well as increasing employment, encouraging better medication compliance and generally improving the individual's quality of life within the community.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP D

Entire State

D. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT

- 1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychosocial, educational, financial and other services.

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COMMUNICATIONS SECTION

2. Case Management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service who have problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective case management must address quality, adequacy and continuity of service, and balance a concern for affordable service with assuring that eligible individuals receive the services appropriate to their needs. Targeted groups consist of functionally limited persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human services providers.
3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing knowledge of services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in the most appropriate environment.
4. Case management empowers individuals by involving them in the decision making process, and allowing them to choose among all available options as a means of moving to the optimum situation where these individuals and their support system can address their needs. Case management implies utilization and development of such support networks as will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

#### DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "D"

Case management for Target Group "D" means those activities performed by case management staff related to ensuring that the mentally disabled individual has full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

Case management for Target Group "D" requires referral to and coordination with medical, social, educational, psycho-social, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the mentally ill individual.

#### CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient's circumstances and therefore must be determined individually in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided.

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- A. **Intake and screening.** This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payors for services.
- B. **Assessment and reassessment.** During this phase the case manager must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.
- C. **Case management plan and coordination.** The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, a cost-conscious selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:
1. the integration of clinical care plans throughout the case management process;
  2. the continuity of service;
  3. the avoidance of duplication of service (including case management services); and,
  4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.
- D. **Implementation of the case management plan.** Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.

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- E. **Crisis intervention.** Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.
- F. **Monitoring and follow-up.** As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring the recipient's satisfaction with the services provided and advising the preparer of the case management plan of the findings; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.
- G. **Counseling and exit planning.** This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of services; mediating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. **Assessments.** The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph B of CASE MANAGEMENT FUNCTIONS.

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

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An assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. **Case management plan.** A written case management plan must be completed by the case manager for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include, but is not limited to, those activities outlined in paragraph C under **CASE MANAGEMENT FUNCTIONS**.

The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

- a. those activities which the recipient is expected to undertake within a given period of time toward the accomplishment of each case management goal;
  - b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
  - c. the type of treatment program or service providers to which the recipient will be referred;
  - d. the method of provision and those activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and
  - e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed.
3. **Continuity of service.** Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is no longer required by the recipient; the recipient moves from the social services district; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services; or, the recipient's case is appropriately transferred to another case manager.

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Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

\* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area. Although equally qualified, each OMH entity is not capable of serving clients in all other parts of the State since serving this clientele requires frequent contact and an intimate knowledge of the support system in the client's community. The current case manager is responsible to help transition clients to case managers in their new location or, if a program is not available, to the best substitute. Clients are free to choose among qualified providers within the State.

#### LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;
3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;
4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver.

While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;

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4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, SNF, ICFs and ICF/MRs; and
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

**LIMITATIONS SPECIFIC TO TARGET GROUP "D"**

In order to support an intensive, personal and proactive service, Intensive Case Managers will carry an average active case load of twelve clients. Active adult ICM clients are seen a minimum of four times during a month. Active seriously emotionally disturbed children in the ICM program must receive four contacts during a month, three face-to-face and the fourth face-to-face may be with either the client or a collateral. Collaterals are defined in 14 NYCRR Part 587.4(a)(3) as members of the patient's family or household, or significant others who regularly interact with the patient and are directly affected by or have the capability of affecting the patient's condition and are identified in the treatment plan as having a role in treatment and/or identified in the pre-admission notes as being necessary for participation in the evaluation and assessment of the patient prior to admission. Each Office of Mental Health Regional Office shall maintain a listing by name (roster) of individuals meeting the basic participation criteria. These individuals may be referred to the roster by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact. From these prospective clients, the Intensive Case Manager will determine which are viable to become active (i.e. that the client can be engaged in activities directed at fulfilling a case plan based on the goals of the program.)

If an active client has fewer than the minimum required face-to-face meetings described above during a month for two continuous months, she/he will be evaluated for return to the roster. Clients returned to rostered status may be placed back into active status expeditiously when the need arises.

**E. QUALIFICATIONS OF PROVIDERS**

**1. Providers**

Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services who are approved by the New York State Commissioner of Social Services based upon an approved proposal submitted to the New York State Department of Social Services. Providers may include:

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- a. facilities licensed or certified under New York State law or regulation;
- b. health care or social work professionals licensed or certified in accordance with New York State law;
- c. state and local governmental agencies; and
- d. home health agencies certified under New York State law.

2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of care management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

- a. one year of case management experience and a degree in a health or human services field; or
- b. one year of case management experience and an additional year of experience in other activities with the target population; or
- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans; or
- d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. Qualifications of Providers Specific to Target Group "D"

1. Providers

The New York State Department of Social Services will authorize as ICM providers either employees of the New York State Office of Mental Health meeting the qualifications described below or employees of those organizations determined by OMH and certified to SDSS to have the capacity to provide specialized Intensive Case Management Services.

2. Case Manager

Minimum Qualifications for Appointment As An Intensive Case Manager

A bachelor's degree in a human services field\* or a NYS teacher's certificate for which a bachelor's degree is required, and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a

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broad range of services essential to successfully living in a community setting, (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

A master's degree in human services field\* may be substituted for two years of the required experience.

Minimum Qualifications for Appointment As A Coordinator of Intensive Case Management Services

A master's degree in a human services field\* and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a broad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services). Two years of this experience must have involved supervisory or managerial experience for a mental health program or major mental health program component.

- \* For purposes of qualifying for these titles a "Human Services Field" includes Social Work, Psychology, Nursing, Rehabilitation, Education, Occupational Therapy, Physical Therapy, Recreation or Recreation Therapy, Counseling, Community Mental Health, Child and Family Studies, Speech and Hearing, Sociology..

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: New York

CASE MANAGEMENT SERVICES

A. Target Group:  
Target Group D1

B. Areas of State in which services will be provided:

- Entire State.
- Only in the following geographic areas (authority of section 1915(g)(1)) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:  
See attached

E. Qualifications of Providers:  
See attached

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

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G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

A. TARGET GROUP D1

The targeted group consists of medical assistance eligibles who are served by the Office of Mental Health's (OMH) Flexible Intensive Case Management Program and who:

- (i) are seriously and persistently (chronically) mentally ill and
- (ii) require intensive, personal and proactive intervention to help them obtain services, which will permit or enhance functioning in the community and
- (iii) either have symptomology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

These individuals include:

- (1) high risk/heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. They may also have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities;
- (2) extended care state psychiatric center patients who could be discharged but are not because of the absence of needed support in the community;
- (3) mentally ill who are homeless and live on the streets or in shelters;
- (4) seriously mentally ill children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and who might, without invention, be institutionalized, incarcerated or hospitalized.

The aim to benefit these clients by reducing hospitalization and reliance on emergency psychiatric services, as well as by increasing employment, encouraging better medication compliance and generally improving the individual's quality of life within the community.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP D1

Statewide

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C. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

**BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT**

1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychosocial, educational, financial and other services.
2. Case Management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service who have problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective case management must address quality, adequacy and continuity of service, and balance a concern for affordable services while assuring that eligible individuals receive the services appropriate to their needs. Targeted groups consist of functionally limited persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human services providers.
3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing information regarding services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in the most appropriate environment.
4. Case management empowers individuals by involving them in the decision making process, and allowing them to choose among all available options as a means of moving to the optimum situation where these individuals and their support systems can address their needs. Case management implies utilization and development of support networks that will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

**DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "D1"**

Case management for Target Group "D1" means those activities performed by case management staff related to ensuring that the mentally disabled individual has full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

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Case management for Target Group "D1" requires referral to and coordination with medical, social, educational, psycho-social, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the mentally ill individual.

**CASE MANAGEMENT FUNCTIONS**

Case management functions are determined by the recipient's circumstances and therefore must be determined individually in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided.

*Added  
2/2/01*

- A. Intake and screening. This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payors for services.
- B. Assessment and reassessment. During this phase the case manager or case management team must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.
- C. Case management plan and coordination. The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, a cost-conscious selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:

1. the integration of clinical care plans throughout the case management process;
  2. the continuity of service;
  3. the avoidance of duplication of service (including case management services); and
  4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.
- D. Implementation of the case management plan. Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of services; and developing alternative services to assure continuity in the event of service disruption.
- E. Crisis intervention. Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances, determination of the recipient's emergency service needs, and revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.
- F. Monitoring and follow-up. As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring the recipient's satisfaction with the services provided and advising the preparer of the case management plan of the findings; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.
- G. Counseling and exit planning. This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of services; mediating among the recipient, the family network and/or other

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informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments. The case management process must be initiated by the recipient and case manager, case management team, or practitioners as appropriate, through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph B of CASE MANAGEMENT FUNCTIONS.

An assessment shall be initiated within fifteen days and must be completed by a case manager or case management team within 30 days or as specified in a referral agreement. The referral for services may include a plan of care containing significant information developed by the referral source which should be included as in integral part of the case management plan.

An assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. Case management plan. A written case management plan must be completed by the case manager or case management team for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include, but is not limited to, those activities outlined in paragraph C under CASE MANAGEMENT FUNCTIONS.

The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment and must address those needs necessary to achieve

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and maintain stabilization. The case management plan must be reviewed and updated by the case manager or case management team as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be renewed or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

- a. those activities which the recipient is expected to undertake within a given period of time toward the accomplishment of each case management goal;
  - b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
  - c. the type of treatment program or service providers to which the recipient will be referred;
  - d. those activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and the method by which those activities will be performed, and
  - e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed.
3. Continuity of service. Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is no longer required by the recipient; the recipient moves from the social services district; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services; or the recipient's case is appropriately transferred to another case manager.

Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager or case management team at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Health.

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NEW YORK

Supplement 1 to Attachment 3.1A  
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LIMITATIONS TO THE PROVISION OF MEDICAID CASE  
MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;
3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;
4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Waiver except as provided for in July 25, 2000 HCFA letter to State Medicaid Directors (Olmstead Update No. 3) which informed the States that Targeted Case Management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community.

While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;

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5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, SNF, ICFs and ICF/MRs; and
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

#### LIMITATIONS SPECIFIC TO TARGET GROUP "D1"

In order to support an intensive, personal and proactive service, Intensive Case Managers will carry an average active case load of twelve clients. Active adult ICM clients must be seen a minimum of two times during a month, but the program must provide in the aggregate a minimum of four visits times the number of Medicaid eligible clients per month per case manager. Active seriously emotionally disturbed children in the ICM program must be seen a minimum of two times during a month, but a maximum of one-quarter of the required total aggregate face-to-face contacts may be with collaterals as defined in 14 NYCRR Part 587. Individuals may be referred to the program by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact. From these prospective clients, the Intensive Case Manager or Case Management team will determine which clients are suitable candidates for Intensive Case management (i.e., that the client can be engaged in activities directed at fulfilling a case plan based on the goals of the program.)

If an active client has fewer than the minimum required face-to-face meetings described above during a month for two continuous months, she/he will be evaluated for disenrollment. Clients ready for disenrollment may be placed into transitional status for a period not to exceed two months, and during that period the program/provider can bill for a maximum face to face contact of one visit per month. Clients who are disenrolled may be placed back into active status expeditiously when the need arises.

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**E. QUALIFICATIONS OF PROVIDERS****1. Providers**

Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services who are approved by the New York State Office of Mental Health and certified to the Department of Health (DOH) to have the capacity to provide specialized Intensive Case Management Services, so that DOH can enroll the providers in the Medicaid program. Providers may include:

- a. facilities licensed or certified under New York State law or regulation;
- b. health care or social work professionals licensed or certified in accordance with New York State law;
- c. state and local governmental agencies; and
- d. home health agencies certified under New York State law.

**2. Case Managers**

The case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

- a. one year of case management experience and a degree in a health or human services field; or
- b. one year of case management experience and an additional year of experience in other activities with the target population; or

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- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development or case management plans; or
  - d. the individual meets the regulatory requirements for case manager of a State Department within New York State.
3. Qualifications of Providers Specific to Target Group "D1"

1. Providers

The New York State Office of Mental Health will authorize as ICM providers either employees of the New York State Office of Mental Health meeting the qualifications described below or employees of those organizations approved by OMH and certified to the Department of Health (DOH) to have the capacity to provide specialized Intensive Case Management Services, in order for the DOH to enroll the providers in the Medicaid program.

2. Case Manager

Minimum Qualifications for Appointment As An Intensive Case Manager

A bachelor's degree in a human services field\* or a NYS teacher's certificate for which a bachelor's degree is required, and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a broad range of services essential to successfully living in a community setting, (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

A master's degree in human services field\* may be substituted for two years of the required experience.

Minimum Qualifications for Appointment As A Coordinator of Intensive Case Management Services

A master's degree in a human services field\* and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally

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disabled patients/clients to a broad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services). Two years of this experience must have involved supervisory or managerial experience for a mental health program or major mental health program component.

- \* For purposes of qualifying for these titles a "Human Services Field" includes Social Work, Psychology, Nursing, Rehabilitation, Education, Occupational Therapy, Physical Therapy, Recreation or Recreation Therapy, Counseling, Community Mental Health, Child and Family Studies, Speech and Hearing, Sociology.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: New York State

CASE MANAGEMENT SERVICES

A. Target Group:

See attached Target Group D2

B. Areas of State in which services will be provided:

- Entire State.
- Only in the following geographic areas (authority of section 1915(g)(1)) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualifications of Providers:

See attached

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to

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public agencies or private entities under other program authorities for this same purpose.

A. TARGET GROUP D2

The targeted group consists of medical assistance eligibles who are served by the Office of Mental Health's Blended and Flexible Case Management Program and who:

- (I) are seriously and persistently (chronically) mentally ill, or seriously mentally ill and
- (ii) require intensive, personal and proactive intervention to help them obtain services, which will permit or enhance functioning in the community, or require personal and proactive intervention to help them obtain and maintain services, which will permit or enhance functioning in the community; and
- (iii) either have symptomatology which is difficult to treat in the existing mental health care system, or are unwilling or unable to adapt to the existing mental health care system, or need support to maintain their treatment connections and/or residential settings.

These individuals include:

- (1) high risk/heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. May have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities, or
- (2) persons with recent hospitalizations in either State psychiatric centers or acute care general hospitals, or
- (2) extended care state psychiatric center patients who could be discharged but are not because of the absence of needed support in the community; or
- (3) mentally ill who are homeless and live on the streets or in shelters; or
- (4) seriously mentally ill children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and who may, without invention, be institutionalized, incarcerated or hospitalized, or
- (5) people in need of ongoing mental health support in order to maintain or enhance community tenure.

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The aim is to benefit these clients by reducing hospitalization and reliance on emergency psychiatric services, as well as by increasing employment, encouraging better medication compliance and generally improving the client's quality of life within the community.

**B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP D2**

Entire State

**C. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID**

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

**BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT**

1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychosocial, educational, financial and other services.
2. Case Management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service who have problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective case management must address quality, adequacy and continuity of service, and balance a concern for affordable service while assuring that eligible individuals receive the services appropriate to their needs. Targeted groups consist of functionally limited persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human services providers.
3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing them with information regarding the services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in the most appropriate environment.
4. Case management empowers individuals by involving them in the decision making process, and allowing them to choose among all available options as a means of

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moving to the optimum situation in which these individuals and their support system can address their needs. Case management implies utilization and development of such support networks as will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

#### DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "D2"

Case management for Target Group "D2" means those activities performed by case management staff related to ensuring that the mentally disabled individual has full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

Case management for Target Group "D2" requires referral to and coordination with medical, social, educational, psycho-social, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the mentally ill individual.

#### CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient's circumstances and therefore must be determined individually in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services which documents each case management function provided.

- A. Intake and screening. This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payors for services.
- B. Assessment and reassessment. During this phase the case management team must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.

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- C. Case management plan and coordination. The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, a cost-conscious selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:
1. the integration of clinical care plans throughout the case management process;
  2. the continuity of service;
  3. the avoidance of duplication of service (including case management services); and,
  4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.
- D. Implementation of the case management plan. Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.
- E. Crisis intervention. Crisis intervention by a case management team includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.
- F. Monitoring and follow-up. As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring the recipient's satisfaction with the services provided and advising the preparer of the case

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management plan whether the recipient is satisfied; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

- G. Counseling and exit planning. This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of services; mediating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

- 1. Assessments. The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph B of CASE MANAGEMENT FUNCTIONS.

An assessment must be completed by a case management team within 30 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as in integral part of the case management plan.

An assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

- 2. Case management plan. A written case management plan must be completed by the

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case management team for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include, but is not limited to, those activities outlined in paragraph C under CASE MANAGEMENT FUNCTIONS.

The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment and must be address those needs necessary to achieve and maintain stabilization.

The case management plan must be reviewed and updated by the case management team as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

- a. those activities which the recipient is expected to undertake within a given period of time for purposes of accomplishing each case management goal;
  - b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
  - c. the type of treatment program or service providers to which the recipient will be referred;
  - d. the activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and the method by which such services shall be provided;
  - e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed; and
  - f. whether the program plans to place a client into transitional status during the next six month period covered by the plan.
3. Continuity of service. Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is

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no longer required by the recipient; the recipient moves from the social services district; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services.

Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Office of Mental Health.

**LIMITATIONS TO THE PROVISION OF MEDICAID CASE  
MANAGEMENT SERVICES**

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;
3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;
4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Waiver except as addressed in the July 25, 2000 HCFA letter to State Medicaid Directors which informed the States that Targeted case management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community.

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While the activities of case management services secure access to an individual's needed service for the client, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, SNF, ICFs and ICF/MRs; and
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

**LIMITATIONS SPECIFIC TO TARGET GROUP "D2"**

In order to support an intensive, personal and proactive service, Blended and Flexible Case Managers will carry case loads based on their designation as Intensive Case Managers or Supportive Case Managers. Intensive Case Managers are responsible to provide a minimum of 48 total monthly face to face contacts per manager. Supportive Case Managers are required to provide in the aggregate a minimum of twice the number of visits as the number of Supportive Case management clients. For children's programs, a maximum of 25% of the total aggregate visits can be face-to-face contacts with collaterals as defined in 14 NYCRR Part 587.

Individuals may be referred to case management by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact. From these prospective clients, the Blended and Flexible Case Management Program will determine which clients are appropriate for case management services and at what level (i.e., that the client can be engaged in activities directed at fulfilling a case plan based on the goals of the program.)

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Clients who appear ready for disenrollment from the program can be placed into transitional status for a period not to exceed two months. During that time period the program can bill for the client as long as at least one face-to-face contact per month is provided. Clients who are disenrolled may be placed back into active status expeditiously when the need arises.

E. QUALIFICATIONS OF PROVIDERS

1. Providers

New York State Office of Mental Health (OMH) will authorize as Case Management providers either OMH employees meeting the qualifications approved below or employees of those organizations determined by OMH and certified to the DOH to have the capacity to provide specialized Case Management Services and having written agreements with appropriate mental health providers and other human service providers so that DOH can enroll the providers in the Medicaid program. Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services that are approved by OMH. Providers may include:

- a. facilities licensed or certified under New York State law or regulation;
- b. health care or social work professionals licensed or certified in accordance with New York State law;
- c. state and local governmental agencies; and
- d. home health agencies certified under New York State law.

2. Case Managers

**Intensive Case Managers:** The Intensive Case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

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- a. one year of case management experience and a degree in a health or human services field; or
- b. one year of case management experience and an additional year of experience in other activities with the target population; or
- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development or case management plans; or
- d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

**Supportive Case Managers:** Must have two years in providing direct services or in a substantial number of activities outlined under "Case Management Functions" to people who are mentally disabled, or homeless. The following may be substituted for this requirement:

- a. One year of case management experience and an associate degree in a health or human services field: or
- b. One year of case management experience and an additional year of experience in other activities with the target population; or
- c. A bachelor's or master's degree which includes a practicum encompassing a substantial number of activities with the target population; or
- d. The individual meets the regulatory requirements for case manager of a State Department within New York State.

Minimum Qualifications for Appointment As A Coordinator of Blended and Flexible Case Management Services

A master's degree in a human services field\* and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a broad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing

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and financial services). Two years of this experience must have involved supervisory or managerial experience for a mental health program or major mental health program component.

- \* For purposes of qualifying for these titles a "Human Services Field" includes Social Work, Psychology, Nursing, Rehabilitation, Education, Occupational Therapy, Physical Therapy, Recreation or Recreation Therapy, Counseling, Community Mental Health, Child and Family Studies, Speech and Hearing, Sociology.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT **90-56**

State/Territory: New York State

**CASE MANAGEMENT SERVICES**

**A. Target Group:**

See attached Target Group E

**B. Areas of State in which services will be provided:**

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

Services to this target population may be provided to residents of Kings County (Zip Codes 11203, 11212, 11213, 11216, 11221, 11225, 11233 and 11236), Bronx County (Zip Codes 10454, 10455, 10451, 10474 and 10459), New York County (Zip Codes 10026, 10027, 10030, 10031, 10037 and 10039)

**C. Comparability of Services**

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

**D. Definition of Services:**

See attached

**E. Qualification of Providers:**

See attached

FB No. 90-56

Revised

FB No. 90-42

Approval Date MAR 3 1992

Effective Date OCT 1 1990

Revision:

HCFA-PN-87-4

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March 1987

OMB No.: 0939-0193

State/Territory: New York State

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TM No. 90-56

Supersedes

TM No. Now

Approval Date MAR 8 1987

Effective Date OCT 1 1980

HCFA ID: 1040P/0016P

A. TARGET GROUP

This target group consists of any categorically needy or medically needy individual who meets the following criteria:

1. Women of child bearing age who are pregnant or parenting, and
2. Infants under 1 year of age.

One of the most serious public health problems we are facing today is that of infant mortality. The problem is especially severe in certain urban areas among poor minority groups where the infant mortality rate is up to 3 times that of the population at large. Other factors which contribute to this problem are women who receive late or no prenatal care. Recent changes to Federal and New York State Law have expanded eligibility benefits to pregnant women and infants. Case management programs are expected to identify women who are at risk and assist them in accessing health care and other resources which they need to assure positive birth outcomes.

In some areas of New York City almost twenty percent of the infants born to minority women are low birth weight babies who are vulnerable to infections and sudden infant death syndrome as well as complications related to low birth weight itself.

Certain upstate cities mirror these rates in their center city areas. Case management will assist in assuring that mothers in these areas can avail themselves of health and social services to properly care for their infants.

In the areas in question, about 20% of the births are to teenage mothers and up to 75% are out of wedlock. The mothers in question are often inexperienced at heading a family and do not have the social supports available in an intact family, and as such have a great need for case management services to assist them in obtaining needed services for themselves and their infants.

After years of steady decline, infant mortality rates have once again begun to climb since 1987. Much of this increase can be laid at the feet of increasing use of illegal drugs and alcohol on the part of poor women in urban areas. In births where toxicity for illegal drugs is found, in New York City, infant mortality is an astronomical 34 in 1,000.

New York State hopes to attack these problems in a site-specific manner using case managers to pull together both Title XIX services and services from other funding streams to meet the needs of pregnant women and infants.

IN \_\_\_\_\_ 90-56 \_\_\_\_\_ approval Date MAR 3 1992  
Supervisor \_\_\_\_\_ Effective Date 0CT 1 1990

B. AREAS OF THE STATE WHERE SERVICES MAY BE PROVIDED

Services to this target population may be provided to residents of Kings County (Zip Codes: 11203, 11212, 11213, 11216, 11221, 11225, 11233 and 11238), Bronx County (Zip Codes: 10454, 10455, 10451, 10474 and 10453), New York County (Zip Codes: 10026, 10027, 10030, 10031, 10037 and 10039) and Onondaga County, New York.

C. COMPARABILITY OF SERVICES

Services will only be provided to those individuals who meet one or more of the criteria set forth in Section A, Target Group, of this Supplement.

Case management services will be provided without limitation as to amount, duration or scope.

D. DEFINITION OF CASE MANAGEMENT SERVICES TO PREGNANT AND PARENTING WOMEN AND INFANTS

Case management is a process which will assist persons eligible for medical assistance to access needed medical, social, educational, and other services in accordance with a written case management plan.

Case management for this target group will be provided in the following fashion.

1. Referral

Referrals of Medicaid eligible women and infants who are part of the target population are made by prenatal and pediatric care providers in the areas involved. Other possible referral sources include alcohol and substance abuse services providers, schools, social agencies and local governmental agencies administering the Medicaid program, child protective and preventive services, programs under Title V of the Social Security Act and Section 17 of the Child Nutrition Act.

Hospitals in the target areas are encouraged to refer women who deliver at their facilities, who have received little or no prenatal care, test positive for illicit drugs or deliver low birth weight babies to case management agencies. Other women from the target areas will also be encouraged to participate because of the higher level of risk which they and their infants face.

The referral activity as outlined is included to add dimension to the problems faced by the target population and to show the degree to which existing service providers will be involved in the identification and referral of such clients. Successful case management for these clients depends in great part on the ability of the case manager to develop good working relationships with service providers. This includes becoming a recognized resource within the broader provider community i.e., a service to which clients may be referred.

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These referral activities are not a function of the case manager; begin prior to the receipt of case management services; and are not billed as Medicaid case management.

2. Engagement

Based on the referral from the hospital, prenatal care or other provider or local governmental agency, the case management agency attempts to interest the Medicaid eligible woman/infant in case management services. Because women in high poverty areas, especially those who use illegal drugs or alcohol, are hard to engage for services, agencies are encouraged to make a number of attempts to contact the woman.

If a woman accepts services, she is then enrolled by the case management agency. In areas where there are multiple agencies providing services, each agency will be required to explain to the woman that she has her choice of case management providers.

3. Assessment/Reassessment

Within 15 days of the acceptance of case management services, the case manager must complete an initial assessment. This will include an evaluation of the met and unmet needs of the woman and her children, her strengths and weaknesses, both formal and informal supports and identification of providers of service, including other case management resources.

It is anticipated that the initial assessment will concentrate on the immediate issues of the woman and her children's health and safety, substance abuse problems and family functioning. Subsequent reassessments (required at four month intervals) will likely deal with the family's longer term needs such as education, safe housing, training and employment for economic security.

4. Case Management Plan Development

Within 30 days of the acceptance of case management services, the case manager must complete development of an initial services plan for the woman and her family. Individuals residing together mutually impact upon each other in terms of their activities and their needs. To deliver effective case management, the family structure, whatever it may be, needs to be taken into account. Family supports and family stressors have a significant impact on the client. If a "parenting" woman (targeted) is having parenting problems with a 2 year old (non-targeted) or needs to arrange for child care in order to participate in a substance abuse treatment program, the case manager must address these needs in the woman's case management plan.

Case managers will not do assessments or case management plans for non-Medicaid eligible persons and will only assist non-Medicaid eligibles in obtaining services, when obtaining that service has a direct impact on the Medicaid eligible member of the target group.

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Medicaid funding will not be used to provide case management services to non-Medicaid eligible family members. Based on the assessment and developed in conjunction with the client, the services plan should include the type and frequency of services needed and the method of obtaining them. Also included in the plan should be timeframes for achieving the objectives and the anticipated frequency of case management.

As in the case of the initial assessment, the initial plan will likely focus on the immediate service needs to insure health and safety of the woman and her children. Once these objectives are achieved, longer term planning for improvements in housing, education and employment will become basic to the plan.

The services plan in question must indicate where and by whom each service is to be delivered; the case manager will be responsible for assuring the delivery of services outlined in the plan. Each woman will have only one Medicaid reimbursed case manager. The services plan should be signed by the woman to show her agreement and willingness to participate.

5. Plan implementation

The case manager assists the woman in acquiring those services which have been identified in the plan as being necessary. In many instances this will require an advocacy role on the part of the case manager in attempting to obtain priorities for the woman and her children within services networks which are already seriously taxed.

The case manager might be required to escort the woman to appointments, at least initially, until she becomes familiar with the parties and processes involved in service provision.

Service acquisition to implement the case management plan will be crucial to the success of the program. It will be necessary to develop priority consideration for such services as clinic appointments, substance abuse services and day care for the program.

6. Monitoring

Monitoring includes assuring that the services were received and that they are appropriate and of acceptable quality and that the client is satisfied that they are meeting the needs of herself and her family. The primary source for obtaining this information is from the woman herself, but case managers should also maintain contact with service providers to assure that the client is making progress and utilizing services properly.

Certain services are dependent on other services. For instance, the case manager will want to be certain that a woman using child care is actually getting active drug or alcohol treatment during the times that the child is being cared for.

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7. Crisis Intervention

With a population which engages in substance abuse, does not respond to health needs until they become emergent and lives in dangerous, unsafe and unhealthy housing, the potential for crisis is measurably increased. For this reason, case management agencies should prepare a crisis plan for individual clients to advise them where to turn in an emergency, as well as having an agency plan to assist clients on a 24 hour a day basis, if necessary.

It is not essential that the case manager be available on a 24 hour basis, but only that the agency have a viable plan for dealing with after hour emergencies.

In addition, the agency must be prepared to revise the services plan almost immediately if the crisis has lasting repercussions or requires a change in the mix or intensity of services.

8. Counseling and Exit Planning

The best case management practices help build self-esteem and improve the client's ability to function more independently thus reducing or eliminating the need for further case management. As the case management becomes less intense, the client should be encouraged to participate in the development and implementation of her own plan objective.

When the case manager determines, in conjunction with the client, that case management is no longer necessary or if the woman loses program eligibility or moves to a different area or service system, the case manager should assist her in moving to new providers or sources of services. With the client's consent, a final assessment and case summary should be prepared and forwarded to the new case manager or services source.

E. QUALIFICATIONS

1. Provider Agency Qualifications

Agencies may be qualified in one of the following ways.

- a. One year of experience in providing case management services to pregnant or parenting women or infants.
- b. Two years of experience in providing health care or social services to pregnant or parenting women or infants.
- c. Two years of experience in providing drug or alcohol abuse treatment services to pregnant or parenting women.
- d. Two years of experience in providing protective services for children or services to prevent their placement in foster care.

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These qualifications may be met by the agency itself or may be met by an individual who has management experience in such an agency and assumes responsibility for the overall administration of the case management program.

2. Staff Qualifications

a. Case Manager

An individual with a Bachelors or Masters degree in Nursing, Social Work, Health Education or a related field. If the degree is in a related field, one year of case management experience is required.

b. Associate Case Manager/Community Health Worker/Community Advocate

Associate Case Managers (ACM/Community Health Workers (CHW/Community Advocate (CA) describe persons residing in the community who assist case managers to monitor and reach clients who do not routinely access organized medical care or entitlements or who may be reluctant to access help from organizations. These individuals are not providers of case management, but are part of the team approach to case management encouraged by this program. They may assist case managers in locating individuals in the community, maintaining contact and gaining acceptance and cooperation for the program and it's goals.

These individual's must have two years of experience as case aides or similar experience with the target group. One year of this experience may be fulfilled by an intensive training program, approved by the State Medicaid Agency.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

CASE MANAGEMENT SERVICES

A. Target Group:  
See attached Target Group F

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

- City of Newburgh, Orange County
- City of Fulton, Oswego County
- Addison School District, Steuben County

C. Comparability of Services

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See pages 1-F7 and 1-F8

TM No. 94-29  
Supersedes  
TM No. 92-68

Approval Date AUG 18 1994

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New York State

Revision: HCFA-PN-87-4

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OMB No.: 0939-0193

State/Territory: New York State

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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TM No. 92-68

Supersedes

TM No. **New**

Approval Date MAR 8 - 1994

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HCFA ID: 1040P/0016P

**A. TARGETED GROUP** F

The targeted group consists of the categorically needy or medically needy who meet one or more of the following criteria.

Certain individuals residing in areas of New York State designated as underserved and economically distressed through the State's Neighborhood Based Alliance (NBA) initiative. Under Chapter 657 of the Laws of 1990, the NBA is targeting state money, resources and services to designated areas in order to alleviate the pervasive and detrimental effects of poverty, lack of access to services and lack of services. Case management targeted individuals are those residents of the NBA area who are experiencing chronic or significant individual or family dysfunctions which might be ameliorated through effective case management referral and monitoring of service provision. Such dysfunctions are assessed as chronic or significant by the case manager in accordance with an assessment tool approved by the State Department of Social Services. The assessment will determine chronic or significant dysfunction on the following categories or characteristics:

- (i) school dropout
- (ii) low academic achievement
- (iii) poor school attendance
- (iv) foster care placement
- (v) physical and/or mental abuse or neglect
- (vi) alcohol and/or substance abuse
- (vii) unemployment/underemployment
- (viii) inadequate housing or homelessness
- (ix) family court system involvement
- (x) criminal justice system involvement
- (xi) poor health care
- (xii) family violence or sexual abuse

**B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP F**

City of Newburgh, New York    Addison School District, New York  
City of Fulton, New York

**C. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID**

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

**DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "F"**

Case managers will assess, and refer the target population to the existing services including these newly available resources and services concentrated in the defined NBA community.

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Case management for Target Group "F" means linkage and referral activities performed by case management staff for individuals who are struggling with the effects of multiple problems compounded by poverty and poor access to services. Through case management, clients will have improved access to the comprehensive array of services and assistance available in the community. Individual needs of the client will be assessed and a case management plan developed.

Case management for Target Group "F" requires referral to and coordination with medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community for the purpose of increasing the client's ability to function independently in the community. The ultimate purpose is to increase the client's level of self-sufficiency.

Case management services to individuals who are not Medicaid eligible will be supported by public and private grant funds. A sliding fee scale for clients based on income level will also be established. Case management will be the means to linking clients to the health, social, economic and educational resources of the community.

#### CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient's circumstances and therefore must be determined specifically in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided, including but not limited to:

- A. **Intake and screening.** This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payers for services.
- B. **Assessment and reassessment.** During this phase the case manager will determine what services the individual needs to access. This determination requires the case manager to secure, as appropriate to the presenting problem, either directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support

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system and environmental factors relative to his/her care. Medical/psychological evaluations shall be obtained indirectly through collateral sources with the permission of the recipient and are not a compensated component of case management.

- C. **Case management plan and coordination.** The activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, type, frequency and duration of services to be provided to the recipient with the participation of the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with other service providers, including informal caregivers and other case managers. It also includes through case management conferences an exchange of clinical information which will assure:
1. case management plans throughout the case management process;
  2. the continuity of service;
  3. the avoidance of duplication of service (including case management services); and,
  4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.
- D. **Implementation of the case management plan.** Implementation of the plan means assisting clients in gaining access to necessary services. Case managers must secure the services determined in the case management plan appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services. Implementation may mean assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing a plan to access alternative services to assure continuity in the event of service disruption.
- E. **Crisis intervention.** Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.
- F. **Monitoring and follow-up.** The case manager is responsible for: assuring that quality services, as identified in the case management plan, are delivered by the provider to whom referral was made; assuring the recipient's satisfaction with the services provided and, if the plan has been formulated by a practitioner

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advising the preparer of the case management plan of the findings; collecting data and documenting the progress of the recipient in the case record; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation and continuation of the case management plan.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. **Assessments.** The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes those activities listed in paragraph B of **CASE MANAGEMENT FUNCTIONS**.

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An updated assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipients condition or circumstances.

2. **Case management plan.** A written case management plan must be completed by the case manager for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include those activities outlined in paragraph C under **CASE MANAGEMENT FUNCTIONS**.

The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

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The case management plan must specify:

- a. those activities which the recipient is expected to undertake within a given period of time toward the accomplishment of each case management goal;
  - b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
  - c. the type of treatment program or service providers to which the recipient will be referred;
  - d. the method of provision and those activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and
  - e. the type, amount, frequency, duration and cost of case management and other services to be delivered or tasks to be performed.
3. **Continuity of service.** Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is no longer required by the recipient; the recipient moves from the target area; the long term goal has been reached; the recipient refuses to accept case management services; the recipient request that his/her case be closed; the recipient is no longer eligible for services; or, the recipient's case is appropriately transferred to another case manager.

Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

- 1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or services or which arranges for the delivery of such care or services on a prepayment basis;
- 2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;
- 3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority.

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While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, NF's;
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

Contact with the client or with a collateral source on the client's behalf must be maintained by the case manager at least monthly, or more frequently as specified in the proposal document submitted for each site.

**E. Qualifications of Providers**

1. **Providers**

Under New York State Regulations (18 NYCRR 505.16) case management services may be provided by social services agencies, facilities, persons and other groups possessing the capabilities to provide such services who are approved by the New York State Commissioner of Social Services based upon approved proposal submitted to the New York State Department of Social Services.

2. **Case Managers**

The case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

- a. one year of case management experience and a degree in a health or human services field; or

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- b. one year of case management experience and an additional year of experience in other activities with the target population; or
- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under **CASE MANAGEMENT FUNCTIONS**, including the performance of assessments and development of case management plans; or
- d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

Provider Qualifications Specific to Target Group "F"

1. **Providers**

The State Department of Social Services designation of providers for this target group will be based upon a proposal document demonstrating the capacity to provide the described services to the target population. The proposal document must be submitted to SDSS, Division of Health and Long Term Care (HLTC) by the local social services district in which an NBA site is located. Qualified agencies will be enrolled as case management providers to serve target populations within the NBA service area.

The NBA lead agencies will provide case management themselves and/or solicit new case managers from community agencies with additional special expertise in the targeted subpopulations. New case managers solicited by the lead agency must meet all provider qualifications, must execute separate provider agreements with the State and must bill the Medicaid program in their own right. The NBA lead agencies are responsible for identification of clients needing case management and referral to the appropriate case management agency. Lead agencies will be responsible for recordkeeping and Medicaid claim preparation only for the case management services they themselves render.

2. **Case Managers**

Case managers will meet the general qualifications described in Item E.2.

Additionally, the staff recruited to work for the case management and crisis intervention program in both a supervisory and direct service capacity will be individuals who are highly committed to the community network concept and have experience working with the variety of cultural and ethnic groups represented in the community. A variety of educational, experiential, and cultural backgrounds will be sought.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

CASE MANAGEMENT SERVICES

A. Target Group: G

See attached.

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

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A. TARGET POPULATION G

The target group consists of any categorically needy or medically needy eligibles

1. who are infants or toddlers from birth through age two years who have or are suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, such as, Down Syndrome or other chromosome abnormalities, sensory impairments, inborn errors of metabolism, or fetal alcohol syndrome.
2. who have been referred to the municipal early intervention agency and are known to the New York State Department of Health.
3. who are in need of ongoing and comprehensive rather than incidental case management.

Developmental delay means that a child has not attained developmental milestones expected for the child's chronological age, as measured by qualified professionals (a multidisciplinary team) using appropriate diagnostic instruments and/or procedures and informed clinical opinion, in one or more of the following areas of development: cognitive, physical (including vision and hearing), communication, social/emotional, or adaptive development. A developmental delay is a delay that has been documented as:

1. a twelve month delay in one functional area, or
2. a 33% delay in one functional area or a 25% delay in each of two areas, or,
3. if appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standards deviations below the mean in each of two functional areas, or
4. if because of a child's age, condition or type of diagnostic instruments available in specific domains, a standardized score is either inappropriate or cannot be determined, a child may be deemed eligible by the informed clinical opinion of the multidisciplinary team. Criteria such as functional status, recent rate of change in development, prognosis for change in the future based on anticipated medical/health factors and other factors relevant to the needs of that child and family shall also be considered.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP G

Entire State

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D. DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "G"

Case management for Target Group "G" means those initial and ongoing activities performed by case management staff related to ensuring that developmentally delayed infants and toddlers are provided access to services allowing them to:

1. resolve problems which will interfere with their independence or self-sufficiency;
2. resolve problems which will interfere with attainment or maintenance of self support or economic independence;
3. maintain themselves in the community rather than reside in, or return to an institution; or
4. prevent institutionalization from occurring.

Case management is a process which will assist Medicaid eligible infants and toddlers and their families to access necessary medical, social, psychological, educational, financial and other services in accordance with the goals contained in a written individualized family services plan (IFSP).

CASE MANAGEMENT FUNCTIONS

Case Management functions are determined by the recipient's circumstances and therefore must be determined specifically in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management service provided.

1. **Intake.** This function consists of: the initial contact to provide information concerning case management and early intervention to the parent of an eligible child or a child thought to be eligible for early intervention services at a time and place convenient to the family; exploration of the family's receptivity to the early intervention program and the case management process; determine that the recipient is a member of the targeted population; ascertain if the child and family are presently receiving case management services or other services from public or private agencies, identification of potential payers for services; and review of due process rights concerning mediation and impartial hearing.

2. **Assessment.** The case manager must secure directly, or indirectly through collateral sources, with the family's permission: a determination of the nature and degree of the recipient's developmental status; must assist the family in accessing screening and evaluation services; review evaluation reports with the family; assist the family to identify their priorities, concerns, and resources; explore options and assist the family's investigation of these options; inform the family of other programs and services that may be of benefit and assist

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in making referrals; assist the recipient in obtaining interim early intervention services when it is determined that the child has an obvious, immediate need and prepare an interim family services plan.

3. **Case management plan and coordination.** For purposes of early intervention, the case management plan will be known as the individualized family services plan (IFSP). Development of the IFSP is the translation of specific goals and objectives, and specific services, providers and timeframes to reach each objective. The case manager shall convene a meeting at a time and place convenient to the family with 45 days of the child's referral to the early intervention agency except under exceptional documented circumstances. Participants shall include: parent(s); early intervention official; case manager; the designated contact from the evaluation team; and other individuals the family invite or give consent to attend.

The IFSP shall be in writing and include the following:

- a. A statement of the child's levels of functioning in each of the following domains: physical development; cognitive development; communication development; social or emotional development; and adaptive development.
- b. A physician's order pertaining to early intervention services, which includes a diagnostic statement and purpose of treatment.
- c. With parental consent, a statement of the family's strengths, priorities, concerns that relate to enhancing the development of their child.
- d. A statement of the major outcomes expected to be achieved and for the child and family, including timelines, and criteria and procedures that will be used to determine whether progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes and services is necessary.
- e. A statement of specific early intervention services necessary to meet the unique needs of the child and family, including the frequency, intensity, location and the method of delivering services.
- f. A statement of the natural environments in which early intervention services will be provided
- g. When early intervention services are to be delivered to a recipient in a group setting without typically developing peers, the IFSP shall document the reason(s).
- h. A statement of other services, including medical services, that are not required under the early intervention program but are needed by the child and the family and the payment mechanism for these services.
- i. A statement of other public programs under which the child and family may be eligible for benefits, and a referral, where indicated.

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j. The projected dates for initiation of services and the anticipated duration of these services.

k. The name of the case manager who will be responsible for the implementation of the IFSP.

l. If applicable, steps to be taken to support the potential transition of the recipient to special education or other services.

m. The IFSP shall reflect the family's response to the plan, consent to case management and/or declination of any part of the plan by the family must be documented.

4. Implementation of the IFSP. In implementing the service plan, the case manager must assist the recipient and family, as needed, in securing the services determined in the plan to be appropriate through referral to agencies or to persons who are qualified to provide identified services; assist the family in making applications for services and entitlements; confirm service delivery dates with providers and supports; assist with family scheduling needs; advocate for the family with all service providers; document services that are not available or cannot be accessed; and developing alternatives services to assure continuity in the event of service disruption.

5. Reassessment and IFSP update. Reassessment is a scheduled or event generated formal reexamination of the client's situation, functioning, clinical and psychosocial needs, to identify changes which have occurred since the initial or most recent assessment. The IFSP for a child and the child's family must be reviewed at six months intervals and evaluated annually, or more frequently if conditions warrant, or if a parent requests such a review.

6. IFSP update implementation. The case manager is responsible for the implementation of the updated plan. Such implementation will include the same activities as described in subsection 4 above.

7. Crisis intervention. Crisis intervention by a case manager includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency needs; and revision of the IFSP, including any changes in activities and objectives required to achieve the established goal.

8. Monitoring and follow-up. The case manager is responsible for:

a. assuring that quality services, as identified in the IFSP, are delivered in a cost-conscious manner;

b. assuring the family's satisfaction with the services provided;

c. collecting data and documenting the progress of the recipient in a case record;

d. making necessary revisions to the plan in conjunction with the family, early intervention official, the designated representative of the evaluation team and the service provider(s);

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- e. making alternate arrangements when services have been denied or are unavailable; and
- f. assisting both the family and providers of service to resolve disagreements, questions or problems relating to the implementation of the IFSP.

9. **Counseling and exit planning.** The case manager must assure that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of service; mediating among the recipient, the family network and/or other informal providers when problems with service delivery occur; facilitating the recipient's access to other appropriate care when eligibility for targeted services ceases; and assisting the family to anticipate difficulties which may be encountered subsequent to from the early intervention program or admission to other programs, including other case management programs.

10. **Supervisory Review/Case Conferencing.** An important component of the required quality assurance process for each case management provider will be supervisory review of case management documentation, IFSPs and other products as well as peer review or case conferencing with other case managers.

#### PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. **Assessments.** The case management process must be initiated by the family and the case manager through a written assessment of the child and family's need for case management and early intervention services including medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the child's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph 2 of CASE MANAGEMENT FUNCTIONS.

The case manager shall promptly arrange a contact with the family at a time, place and manner reasonably convenient for the parent(s) consistent with applicable timeliness requirements and initiate the assessment process. Information developed by the referral source should be included as an integral part of the case management plan.

An assessment of the recipient's need for case management and early intervention services must be completed by the case manager every six months, or sooner if required by changes in the child's condition or circumstances.

2. **Case management plan.** A written IFSP must be completed by the case manager for each child eligible for early intervention services within 45 days of referral to the municipal early intervention agency and must include, but is not limited to, those functions outlined in paragraph 3 under CASE MANAGEMENT FUNCTIONS.

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3. Continuity of service. Case management services must be ongoing from the time the child is referred to the local early intervention agency for services to the time when: when the coordination of services provided through case management is not required or is no longer required by the child and his/her family; the child moves from the local social services district\*; the long term goal has been reached; the family refuses to accept case management services; the family requests that its case be closed; the child is no longer eligible for services; or the child's case is appropriately transferred to another case manager.

Contact with the child, his or her family or with a collateral source on the child's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

\* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area due to a lack of intimate knowledge of the support system in the family's new community. The current case manager is responsible to help transition the family to a case manager in their new location. Clients are free to choose among the case managers qualified to provide early intervention case management services.

#### LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services for Target Group "G":

1. must not be utilized to restrict the choices of the case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services on a prepayment basis;
2. must not duplicate certain case management services currently provided under the Medical Assistance Program or under any other funding sources;
3. must not be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;
4. must not be provided to persons receiving institutional care for more than 30 days or when discharge to community based care is not anticipated and care is reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver or the Care At Home model waiver program.

While the activities of case management services secure access to, including referrals to and arrangements for, services for the Target Group, reimbursement for case management does not include:

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1. the actual provision of the service;
2. Medicaid eligibility determinations and redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization;
6. administration of the Child/Teen Health Program services;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning;
9. client outreach.

E. QUALIFICATIONS OF PROVIDERS SPECIFIC TO TARGET GROUP "G"

1. Provider qualifications

Public or private agencies applying for participation in the Early Intervention Program must demonstrate the following:

- a. character and competence , including fiscal viability;
- b. the capacity to provide case management services;
- c. availability to provide qualified personnel as defined in subsection 2 below;
- d. adherence to applicable federal and state laws and regulations;
- e. the capacity and willingness to ensure case managers participate in inservice training;
- f. the assurance that all case managers will participate in training sponsored by the New York State Department of Health or another State early Intervention agency within the first twelve months of employment;
- g. completion of an approved Medicaid provider agreement.

2. Case manager qualifications

Early Intervention case managers may be located within either public or private agencies, or may be individual qualified personnel. All case managers shall meet the following qualifications:

- a. a minimum of one of the following educational or case management experience credentials:
  - i. two years experience in case management activities (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or
  - ii. one year of case management experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or

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- iii. one year of case management experience and an associates degree in a health or human service field; or
  - iv. a bachelors degree in a health and human service field.
- b. demonstrated knowledge and understanding in the following areas:
- i. infants and toddlers who are eligible for early intervention services;
  - ii. State and federal laws and regulations pertaining to the Early Intervention Program;
  - iii. principles of family centered services;
  - iv. the nature and scope of services available under the Early Intervention Program and the system of payments and services in the State; and,
  - v. other pertinent information.

3. Individual case managers

Qualified personnel with appropriate licensure, certification or registration shall apply to the State Department of Health for approval to provide case management services. In addition, to the qualifications listed in subsection 2. above, the following factors are required for individuals not associated with a public or private agency in order to provide case management services:

- a. current licensure, certification or registration in a discipline eligible to deliver services to children;
- b. adherence to applicable federal and State laws and regulations;
- c. the capacity and willingness to attend in-service training programs sponsored by the Department of Health and State early intervention agencies;
- d. the assurance that all approved individual case managers will participate in the case manager training sponsored by the Department of Health or State early intervention agencies within the first twelve months of program participation;
- e. completion of an approved Medicaid provider agreement.

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Supersedes TN New Effective Date SEP 1 - 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

CASE MANAGEMENT SERVICES

A. Target Group: H

See attached.

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

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MARCH 1987

SUPPLEMENT 1 TO ATTACHMENT 3.1-A  
Page 1-H1a  
OMB No.: 0939-0193

State/Territory: New York State

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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HCFA ID: 1040P/00:

A. TARGET GROUP H

The targeted group consists of Medical Assistance eligibles who are served by the Office of Mental Health's Supportive Case Management Program who:

- (i) are seriously mentally ill; and,
- (ii) require personal and proactive intervention to help them obtain and maintain services, which will permit or enhance functioning in the community; and,
- (iii) either have symptomology which is difficult to treat in the existing mental health care system or need support to maintain their treatment connections and/or residential settings.

These individuals include:

- (1) heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. May have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities; or,
- (2) persons with recent hospitalization in either state psychiatric centers or acute care general hospital; or,
- (3) mentally ill who are homeless and live on the streets or in shelters; or,
- (4) seriously emotionally disturbed children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and may, without intervention, be institutionalized, incarcerated or hospitalized; or,
- (5) people in need of ongoing mental health support in order to maintain or enhance community tenure.

The aim is to benefit these recipients by reducing hospitalization and reliance on emergency psychiatric services, as well as increasing employment, encouraging better medication compliance and generally improving the individual's quality of life within the community.

Supportive Case Management will address the needs and desires of those persons in Target Group "H". Target Group "H" persons will be identified through the screening and intake process. The eligibility determination will be made based on individual factors in each person's life. Factors which will be considered during this process include: status of mental illness, case management options available in the community, residential situation and available options, current linkage to mental health services (including type of service, frequency and duration), linkage or lack thereof to the health care system and/or the Social Services system, the role of the criminal justice system in a person's life, as well as the individual's personal needs and goals. If

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an individual is generally not engaged in at least one of these service systems, he/she may be better served in an Intensive Case Management program and the SCM program will make the appropriate referral and work toward linking that person into ICM. Those persons determined to be in need of Intensive Case Management but who cannot be served due to lack of capacity in ICM program will be served by SCM until the individual circumstances change or the ICM program has space available for the individual.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP H

Entire State

C. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "H"

Case management for Target Group "H" means those activities performed by case management staff related to ensuring that the individuals diagnosed with mental illness have full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

Case management for Target Group "H" requires referral to and coordination with medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the person diagnosed with mental illness.

Supportive case management establishes programming directed toward a comprehensive person-centered view of recovery from mental illness. The Office of Mental Health has designed the SCM initiative to extend the personalized planning, linking, monitoring, and advocacy available through the Intensive Case Management Program target group "D" toward a wider group of persons in need. Called Supportive Case Management, this new program will be available to persons living in the community, homeless persons and persons in community support programs. The intent of the program is to provide for these individuals a comprehensive approach toward meeting their treatment, rehabilitation and support needs.

CASE MANAGEMENT FUNCTIONS

The case manager will assist the recipient in gaining access to each individual's specific area of need (ie. medical, social, education or other service). The case manager will perform needs assessments, develop a plan of care to meet the recipients's needs and interests,

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assist the recipient in accessing the services and perform monitoring and follow-up functions. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided.

- A. Intake and screening. This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and indentifying potential payors for services.
- B. Assessment and reassessment. During this phase the case manager must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.
- C. Case management plan and coordination. The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:
1. the integration of clinical care plans throughout the case management process;
  2. the continuity of service;
  3. the avoidance of duplication of service (including case management services); and
  4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the individual.

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- D. **Implementation of the case management plan.** Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.
- E. **Crisis intervention.** Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipients's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.
- F. **Monitoring and follow up.** As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered; assuring the recipient's satisfaction with the services provided and advising the preparer of the case management plan of the findings; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.
- G. **Counseling and exit planning.** This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing linkages to support groups for the recipient, the recipient's family and informal providers of services; coordinating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. **Assessments.** The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

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An assessment provides verification of the individual's current functioning and continuing need for services, the service priorities and evaluation of the individual's ability to benefit from such services. The assessment process consists of those activities listed in paragraph B of CASE MANAGEMENT FUNCTIONS.

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An assessment of the individual's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. **Case management plan.** A written case management plan must be completed by the case manager for each individual receiving case management services within 30 days of the date of referral or as specified in a referral agreement, and must include those activities outlined in paragraph C, under CASE MANAGEMENT FUNCTIONS.

The individual's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the individual's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

- a. those activities which the individual is expected to undertake within a given period of time toward the accomplishment of each case management goal;
- b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
- c. the type of treatment program or service providers to which the individual will be referred;
- d. the method of provision and those activities to be performed by a service provider or other person to achieve the individual's related goal and objective; and
- e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed.

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3. Continuity of service. Case management services must be ongoing from the time the individual is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is no longer required by the individual; the recipient moves from the social services district\*; the long term goal has been reached; the individual refuses to accept case management services; the individual requests that his/her case be closed; the individual is no longer eligible for services; or, the individual's case is appropriately transferred to another case manager. Contact with the individual or with a collateral source on the individual's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

\* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area. Although equally qualified, each OMH entity is not capable of serving individuals in all other parts of the State since serving this clientele requires frequent contact and an intimate knowledge of the support system in the client's community. The current case manager is responsible to help transition clients to case managers in their new location or, if a program is not available, to the best substitute. Clients are free to choose among qualified providers within the State.

#### LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;
3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;
4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver.

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While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with "lock in" provisions under 1915 (a) of the Social Security Act;
8. institutional discharge planning required of hospitals, SNFS, ICFs and ICF/MRs;
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan; and
10. representative payee services.

**LIMITATIONS SPECIFIC TO TARGET GROUP "H"**

In order to support a personal and proactive service, Supportive Case Managers will carry an average active case load of between 20-30 clients. Supportive Case Managers will see active clients a minimum of two times during a month. SCM employs a team approach to the provision of case management service. The inclusion of the SCM program in the service target group H will assure that the nature and intensity of services vary with individuals changing needs. These individuals may be referred to the SCM by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact.

**D. QUALIFICATIONS OF PROVIDERS SPECIFIC TO TARGET GROUP "H"**

**1. Providers**

The New York State Office of Mental Health (OMH) will authorize as Case Management providers either employees of OMH meeting the qualifications described below or employees of those organizations determined by OMH and certified to the Department of Health (DOH) to have the capacity to provide specialized Case Management Services and

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 Supersedes TN 94-40 Effective Date JAN 01 2001

New York

SUPPLEMENT NO. 1 TO ATTACHMENT 3.1-A  
PAGE 1-H8-a

having written agreements with appropriate mental health providers and other human service providers so that DOH can enroll the providers in the Medicaid program.

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JAN 01 2001

SCM Teams will vary in size and composition and may consist of one individual who may be a paraprofessional with adequate clinical supervision. Each supportive case manager must meet the minimum qualifications for Supportive Case Manager whether they serve a maximum 20 client caseload or a maximum 30 client caseload. The qualifications for Supportive Case Manager whether they serve a maximum 20 client caseload or a maximum 30 client caseload are the same. While supportive case management programs may provide services to individuals with only one staff member and a supervisor in the program, the more common model will utilize a team approach. The team may be comprised of professionals and paraprofessionals. All members of the team must meet the minimum qualifications for the SCM and will receive professional supervision, as detailed in this document. SCM teams will have a professional supervisor with both clinical and supervisory experience.

2. Case Managers

Minimum Qualifications for Supportive Case Manager:

Two years of experience in providing direct services or in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS to people who are mentally disabled, or homeless. The following may be substituted for this requirement:

- a) one year of case management experience and an associates degree in a health or human services field; or
- b) one year of case management experience and an additional year of experience in other activities with the target population; or
- c) a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities with the target population; or
- d) the individual meets the regulatory requirements for case manager of-a State Department within New York State.

Minimum Qualifications for Coordinator of Supportive Case Management Services:

Education:

1. a master's degree in one of the below listed fields\*
- or 2. a master's degree in public administration, business administration, health care or hospital administration and a bachelor's degree in one of the below listed fields\*;
- or 3. NYS licensure and registration as a Registered Nurse plus a master's degree in 1 or 2 above

AND

Experience:

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Supersedes TN New

Four years of experience:

1. in providing direct services to persons diagnosed with mental disabilities\*\*;
- or
2. in linking persons diagnosed with mental disabilities\*\* to a broad range of services essential to successfully living in a community setting (e.g., medical, psychiatric, social, educational, legal, housing and financial services)

Two years of this experience must have involved:

1. supervisory or managerial experience for a mental health program or major mental health program component;
- or
2. service as an Intensive Case Manager in a NYS Office of Mental Health registered ICM program.

\*Qualifying education includes degrees in social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing.

\*\*The term "mental disabilities" refers to persons properly diagnosed with mental illness, mental retardation, alcoholism or substance abuse.

Minimum Qualifications for a Clinical Professional:

Clinical professional staff are individuals who are qualified by credentials, training and experience to provide supervision and direct service related to the treatment of mental illness and shall include: a credentialed alcoholism counselor; registered or certified creative arts therapist; certified nurse practitioner; licensed occupational therapist, physician, psychiatrist, psychologist, or registered professional nurse; registered physician's assistant or specialist's assistant; rehabilitation counselor with a Master's Degree in this field or current certification, pastoral counselor with a Master's Degree or equivalent in this field, certified social worker currently licensed or with a Master's Degree in this field, therapeutic recreation specialist who is registered or has a Master's Degree in this field.

Minimum Supervision Standard for Supportive Case Management Teams:

Supervision of the SCM team will be provided by the SCM Team Coordinator, or an appropriate clinical professional.

Routine review of tasks performed by the SCM team members will focus on enrollment, planning, and service linkage and advocacy. An SCM team meeting for case review will take place monthly or more frequently, if needed. Supervision of the SCM team members with paraprofessional job titles will be provided by a professional, who will be available at all times for consultation with the SCM and will provide direct supervision at frequent intervals to assure that recipient needs are being addressed. Supervision of paraprofessionals by a professional staff member will occur on a bi-weekly basis at a minimum and more frequently, if needed.

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Additionally, the coordinator will review each recipient case record with the SCM team members on a semi-annual basis at a minimum and more frequently, as needed. The SCM Coordinator will post a progress note in the record at the time of the case record review.

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Requesting that  
CMS rescind pages

1-11 - 1-18

of 3.1A, Supplement

letter to CMS 6/8/2010.

Revision:

HCFA-FN-87-4

Supplement 1 to Attachment 3.1A

Page 1-II

OMB No.: 0939-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

CASE MANAGEMENT SERVICES

A. Target Group: I  
See attached Target Group

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See Attached

TM No. 96-41  
Supersedes  
TM No. N.W.

Approval Date 21 21 1990

Effective Date 87-3 1990

HCFA ID: 1040P/0016P

State/Territory: New York State

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

See Attached

TM No. **96-41**  
Supersedes  
TM No. **New**

Approval Date JAN 21 1988

Effective Date 87-3 1988

HCFA ID: 1040P/0016P

**CASE MANAGEMENT SERVICES  
SERVICE COORDINATION FOR CHILDREN WITH DISABILITIES**

**A. TARGET GROUP I:**

Children 3 through 21 years old who are federally eligible Medical Assistance Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) recipients and for whom free and appropriate education is provided under the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973.

A child is eligible to receive the case management services, called Service Coordination for Children with Disabilities under New York's Medical Assistance Program Comprehensive Medicaid Case Management regulations 18 NYCRR 505.16, when all of the following requirements are met:

1. It is determined through an assessment, in accordance with New York State Education law and regulations for assuring a free, appropriate education for all students with disabilities, that:
  - a. the child has temporary or long-term needs arising from cognitive, emotional, or physical factors, or any combination of these, which affects the child's ability to learn, and
  - b. the child's ability to meet general education objectives is impaired to a degree whereby the services available in the general education program are inadequate in preparing the child to achieve his or her education potential.
2. A multi-disciplinary team, called a Committee on Special Education (CSE) or Committee on Preschool Special Education (CPSE) in the New York State Department of Education regulations for Programs for Students with Disabilities, or Multi-Disciplinary Team (MDT) for programs and activities under §504 of the Rehabilitation Act of 1973 determines that the recipient is a child with disabilities who:
  - a. Is eligible for special education and/or related services that are provided through two school Medicaid programs; the Preschool Supportive Health Services Program (PSHSP) for children age 3 and 4 and the School Supportive Health Services Program (SSHSP) for children age 5 through 21, and
  - b. Needs an Individualized Education Program (IEP) under Part B (IDEA) or an Accommodation Plan (AP) under Section 504 of the Rehabilitation Act of 1973.
3. The child elects, or the child's parent or other responsible individual elects on the child's behalf, to receive Service Coordination for Children and Disabilities; and
4. The child is not receiving similar case management services under another Medical Assistance Program authority.

Stamp: **New** JAN 21 1998 JET - 3 1998

**D. DEFINITION OF SERVICES:**

Service Coordination for Children with Disabilities means those case management services which will assist children with or suspected of having disabilities in gaining access to evaluations and the services recommended in a child's IEP or AP.

The New York Medical Assistance Program reimburses for the following services under Service Coordination for Children with Disabilities, when the following case management services have been documented as necessary and appropriate:

1. Initial IEP or AP
  - a. A unit of service for the initial IEP or AP is defined as:
    - (1) The activities leading up to and including writing a completed initial IEP or AP prepared by members of the CSE/CPSE/MDT, the multi-disciplinary team. An initial IEP is a written recommendation identifying the handicapping condition, a description of the child's strengths and weaknesses, a list of goals and objectives that the child should reach in a years time, and an identification of the types of programs and services that the child will receive. An AP is a written document that describes the nature of the problem, evaluations completed, the basis for determining that the child has a disability, and the list of recommended accommodations; and
    - (2) At least one contact by the child's service coordinator or CSE/CPSE/MDT, in person or by telephone with the child or the child's parent or other responsible individual, on the child's behalf, relating to the development of the initial IEP or AP.
  - b. The covered services include convening and conducting the CSE/CPSE/MDT conference to develop an initial IEP or AP. The conference will result in all of the following:
    - (1) A statement of the child's special education needs, and/or related services needs or accommodation needs and services, including the need for medical, physical, mental health, social, financial assistance, counseling, and other support services;
    - (2) A statement of measurable annual goals and measurable short-term objectives for the child;
    - (3) A statement of the specific special education and related services to be provided to the child;

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- (4) The projected dates for initiation of services and the anticipated duration of service;
  - (5) Appropriate objective criteria and evaluation procedures for determining, on at least an annual basis, whether the objectives set forth in the IEP or AP are being achieved; and
  - (6) Parental notification of the recommendation.
- d. Administrative, directive, supervisory, and monitoring services are included as part of the service.

2. Triennial Evaluation - IEP

- a. A triennial evaluation may occur every three years to provide current assessment information on children in special education pursuant to IDEA. A unit of service is defined as:
- (1) The activities leading up to a recommendation based on an appropriate reexamination of each child with a disability by a physician, a school psychologist, and to the extent required by the CSE, by other qualified appropriate professionals; and
  - (2) At least one contact by the child's service coordinator or CSE, in person or by telephone with the child or the child's parent or other responsible individual, on the child's behalf, relating to updating the IEP.
- b. The covered services include convening and conducting the CSE conference to review the results of the triennial evaluation, assessment and revising the IEP, as necessary, that will result in:
- (1) A statement of the child's special education needs and/or related service needs, including the need for medical, mental health, social, financial assistance, counseling, and other support services;
  - (2) A statement of measurable annual goals and measurable short-term objectives for the child;
  - (3) A statement of the specific special education and/or related services to be provided to the child;
  - (4) The projected dates for initiation of services and the anticipated duration of service;

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- (5) Appropriate objective criteria and evaluation procedures for determining, on at least an annual basis, whether the objectives set forth in the IEP or AP are being achieved; and
  - (6) Parental notification of the recommendation.
- c. Administrative, directive, supervisory, and monitoring services are included as part of the service.
3. Annual IEP or AP Review
- a. An annual review is a required CSE/CPSE/MDT meeting which must occur every year to determine whether the existing IEP or AP, is appropriately meeting the child's needs. A unit of service is defined as follows:
- (1) A CSE/CPSE/MDT meeting to discuss yearly progress and make recommendations to continue, change or terminate the program, and
  - (2) At least one contact by the child's service coordinator or CSE/CPSE/MDT, in person or by telephone with the child or the child's parent or other responsible individual, on the child's behalf, relating to updating the IEP or AP.
- b. The covered services include convening and conducting the CSE/CPSE/MDT conference to revise the IEP or AP, as necessary, that will result in:
- (1) A statement of the child's special education needs and/or related service needs or accommodation needs and services, including the need for medical, mental health, social, financial assistance, counseling, and other support services;
  - (2) A statement of measurable annual goals and measurable short-term objectives for the child;
  - (3) A statement of the specific special education and/or related services to be provided to the child;
  - (4) The projected dates for initiation of services and the anticipated duration of service;
  - (5) Appropriate objective criteria and evaluation procedures for determining whether the objectives set forth in the IEP or AP are being achieved; and
  - (6) Parental notification of the recommendation.
- c. Administrative, directive, supervisory, and monitoring services are included as part of the

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service.

4. Requested IEP or AP (Interim) Review

- a. Regulations of the New York State Department of Education require that a child's IEP or AP be reviewed and, if appropriate, revised on an interim basis upon the request of the professionals on the CSE/CPSE/MDT or the request of the child's parent(s) or other responsible individual.
- b. A unit of service for IEP or AP review is defined as:
  - (1) Reconvening the CSE/CPSE/MDT, and
  - (2) At least one contact by the service coordinator or CSE/CPSE/MDT in person or by telephone with the child or the child's parent or other responsible individual, on the child's behalf, relating to review of the IEP or AP.
- c. The covered services include convening and conducting a CSE/CPSE/MDT meeting to review and revise, as necessary, the child's IEP or AP. The meeting will result in a review and parental notification, of the following:
  - (1) The statement of the child's special education needs and/or related service needs or accommodation needs and services, including the need for medical, mental health, social, financial assistance, counseling, and other support services;
  - (2) The statement of measurable annual goals and measurable short-term objectives for the child;
  - (3) The statement of the specific special education and/or related services to be provided to the child;
  - (4) The projected dates for initiation of services and the anticipated duration of service; and
  - (5) The appropriate objective criteria and evaluation procedures to determining whether the objectives set forth in the IEP or AP are being achieved.
- d. Administrative, directive, supervisory, and monitoring services are included as part of the service.

5. Ongoing Service Coordination

- a. Ongoing service coordination is rendered subsequent to implementing a child's IEP or AP by the service coordinator employed by or under contract to a school district.

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- b. A unit of service for ongoing service coordination includes:
- (1) At least two documented contacts per month by the service coordinator relating to the child's ongoing service coordination, and
  - (2) The provision of all other necessary covered services under ongoing service coordination.
- c. These services may include:
- (1) Acting as a central point of contact relating to IEP or AP services for a child,
  - (2) Maintaining contact with direct service providers and with a child and the child's parent or other responsible individual through home visits, office visits, school visits, telephone calls, and follow-up services as necessary,
  - (3) Assisting the child in gaining access to services specified in the IEP or AP, and providing linkage to agreed-upon direct service providers,
  - (4) Discussing with direct service providers that the appropriate services are being provided, following up to identify any obstacles to a child's utilization of services, coordinating the service delivery, and performing ongoing reviews to determine whether the services are being delivered in a consolidated fashion as recommended in the IEP or AP and meet the child's current needs,
  - (5) Providing a child and a child's parent or other responsible individual with information and direction that will assist them in successfully accessing and using the services recommended in the IEP or AP, and
  - (6) Informing a child's parent or other responsible individual of the child's and the family's rights and responsibilities in regard to specific programs and resources recommended in the IEP or AP.
- d. Administrative, directive, supervisory, and monitoring services are included as part of the service.
- E. Qualifications of Providers of Service Coordination for Children with Disabilities:
1. A provider of Service Coordination for Children with Disabilities shall be a school district within the State that:
    - a. Operates and contracts for programs with special education and/or related services/accommodations for children with disabilities, in accordance with Article 89 of Education Law, Section 504 of the Rehabilitation Act of 1973 and Programs for Students

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with Disabilities

(8 NYCRR 200); and

- b. Is enrolled in MMIS as a SSHSP or PSHSP provider.
- F. Qualifications of Service Coordinators:
- 1. An individual recommended as a child's service coordinator shall be:
    - a. Employed by or under contract to a school district;
    - b. Chosen by the CSE/CPSE/MDT, taking into consideration the:
      - (1) Primary disability manifested by the child;
      - (2) Child's needs, and
      - (3) Services recommended in the IEP or AP.
  - 2. A service coordinator must be appropriately licensed or certified and could include an audiologist, school counselor, rehabilitation counselor, registered nurse, practical nurse, occupational therapist, physical therapist, psychologist, social worker, speech therapist, speech pathologist, teacher, school administrator, or school supervisor.
- G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Reimbursement for the development of the IEP or AP is available even if the child's condition is reviewed and not classified, or the parent, on the child's behalf, does not consent to the recommendation and the services are not provided.

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New York  
I-19

Supplement to Attachment 3.1-A  
(09/10)

The New York State Department of Health (NYSDOH) School Supportive Health Services Program (SSHSP) Targeted Case Management (TCM) for Target Group I, which became effective October 3, 1996, will be terminated on July 1, 2010.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

TARGETED CASE MANAGEMENT SERVICES

For First-time Mothers and Newborns

Target Group: M – First-time Mothers and their Newborns

The primary target group consists of low-income, pregnant women who will be first-time mothers and their newborn children up to each child's second birthday. A woman must be enrolled in the targeted case management program during pregnancy, as early as possible, but no later than twenty-eight weeks gestation.

The goals of this program are to improve pregnancy outcomes by providing comprehensive case management services including: 1) assessment of each woman's need for medical, education, social and other services; 2) development of a care plan for each woman with goals and activities to help the woman engage in good preventive health practices; and 3) referral, follow-up and assistance in gaining access to needed services including obtaining prenatal care, improving diets, reducing use of cigarettes, alcohol and illegal substances, improving each child's health and development and reducing quickly recurring and unintended pregnancies.

Areas of State in which services will be provided (Section 1915(g)(1) of the Act):

Entire State

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide):

New York City and Monroe County

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**Comparability of Services (Sections 1902(a)(10)(B) and 1915(g)(1))**

\_\_\_\_\_ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

X  Services are not comparable in amount, duration, and scope. (Section 1915(g)(1)). By enrolling in this targeted case management program, first-time mothers and their newborns will be receiving comprehensive case management services that are not comparable to the amount, duration and scope of services provided to all Medicaid eligible pregnant women.

**Definition of Services (42 CFR 440.169):**

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. This targeted case management program for first-time mothers and their newborns offers a comprehensive set of case management services through home visits by trained registered nurses. Case management services provided include the following:

1. Comprehensive assessment and periodic reassessment of the first-time pregnant woman and her newborn to determine the need for medical, educational, social or other services. These assessment activities include:
  - a) taking the woman's history and assessing her risk for poor birth outcomes;
  - b) identifying the needs of the first-time mother and her newborn and completing related documentation; gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment.
2. Development (and periodic revision) of a specific care plan. A care plan will be developed based on the comprehensive assessment conducted of the first-time mother. A written care plan must be completed by the case manager within 30 days of the date of the woman's referral to the targeted case management program and must include, but not be limited to, the following activities:
  - i. Identification of the nature, amount, frequency and duration and cost of the case management services required by a particular recipient;
  - ii. Selection of the long-term and short-term goals to be achieved through the case management process;

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- iii. Specification of the long-term and short-term goals to be achieved through the case management process;
- iv. Collaboration with health care and other formal and informal service providers, including discharge planners and other case managers as appropriate, through case conferences to encourage exchange of clinical information and to assure:
  - a. the integration of clinical care plans throughout the case management process;
  - b. the continuity of service;
  - c. the avoidance of duplication of services (including case management services) and
  - d. the establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational and financial needs of the recipient.

The care plan will state:

- a) goals and actions to address the medical, social, educational, and other services needed by the woman and child;
- b) activities to ensure the active participation of the first-time mother (or the woman's authorized health care decision maker) and others to develop the goals;
- c) a course of action identified to respond to the assessed needs of the first-time mother and child; and
- d) an agreed upon schedule for re-evaluating goals and course of action.

The plan will be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six (6) months subsequent to the initial plan. Each time the care plan is reviewed, the goals established in the initial plan will either be maintained or revised, and new goals and time frames established.

3. Referral and related activities (such as scheduling appointments for the mother and child) to help the first-time mother and newborn obtain needed services including:

- a) activities that help link the mother and child with medical, social, educational providers or other program and services in the community that are capable of providing needed services to address identified needs, and achieve goals as specified in the care plan.

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## 4. Monitoring and follow-up activities

Monitoring and follow-up activities may be with the first-time mother, other family members or providers. Home visits and other contacts that are necessary to ensure that the care plan is implemented and adequately addresses the mother and newborn's needs will be conducted as frequently as necessary, or at least bi-weekly to determine whether the following conditions are met:

- services are being furnished in accordance with the care plan;
- services in the care plan are adequate and
- if there are changes in the needs or status of the woman and/or her child, then, necessary adjustments in the care plan and service arrangements with providers are made.

X  Case management includes contacts with non-eligible individuals (such as the newborn's father) who are directly related to identifying the needs and care, for the purposes of helping the first-time mother and her child access services; identifying needs and supports to assist the mother and child in obtaining services; providing case managers with useful feedback and altering case managers to changes in the mother or child's needs (42 CFR 440.169(e)).

**Qualifications of Providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):****1. Provider Agencies**

Providers of targeted case management to first-time mothers and their children in the target groups may be public or private agencies and organizations, whether operated on a profit-making or not-for profit basis.

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Case management services may be provided by agencies, facilities, persons and other groups possessing the capability to provide services that are approved by the Commissioner of New York State Department of Health (DOH), the single state Medicaid agency, based upon an approved proposal submitted to the New York State DOH. Providers may include:

- a) facilities licensed or certified under New York State law or regulation as Licensed Home Care Services Agencies (LHCSA) or Certified Home Health Agencies (CHHA);
- b) a county health department, including the health department of the City of New York.

## 2. Case Managers

Case managers must have the education, experience, training and/or knowledge in the areas necessary to conduct case management services including: assess the needs and capabilities of the pregnant or parenting woman and her child; develop a care plan based on the assessment; assist the first-time mother/child in obtaining access to medical, social, education and other services; make referrals to medical, social, educational and other providers; and monitor activities to ensure that the care plan is effectively implemented and addresses the assessed needs. Case managers under this program are required to be registered nurses with BSN degrees; and be licensed as professional nurses with the New York State Department of Education. Certification by a nationally-recognized organization, with an evidence-based program in nurse home visits and case management for high risk, first-time mothers and their newborn is preferred.

Case managers in this targeted case management program will meet or exceed the standards set by the single State Medicaid Agency. The case manager must have two years experience in a substantial number of case management activities. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis.

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The two years of experience may be substituted by:

- a) one year of case management experience and a degree in a health or human services field;
- b) one year case management experience and an additional year of experience in other activities with the target population; or
- c) a bachelor’s or master’s degree which includes a practical encompassing a substantial number of activities with the target population.

As a single state Medicaid agency, criteria for case managers is stated in Administrative Directive 89 ADM-29 for case management provider entities and case management staff under section D entitled Provider Qualifications and Participation Standards.

**Freedom of Choice (42 CFR 441.18(a)(1)):**

The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

- 1. Eligible recipients will have free choice of the providers of case managements services within the specified geographic area identified in this plan.
- 2. Eligible recipients will have free choice of the providers of other medical care under the plan.

**Freedom of Choice Exception (Section 1915(g)(1) and 42 CFR 441.18(b)):**

\_\_\_ Target group consists of eligible individuals with development disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

**Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):**

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual’s access to other services under the plan;

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-Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

-Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

**Payment (42 CFR 441.18(a)(4)):**

Payment for case management services under the plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

Case management providers are paid on a unit-of-service basis that does not exceed 15 minutes. A detailed description of the reimbursement methodology identifying the data used to develop the rate is included in Attachment 4.19B.

**Case Records (42 CFR.18(a)(7)):**

Providers maintain case records that document for all recipients receiving targeted case management services as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) The timeline for obtaining needed services; and (viii) A timeline for reevaluation of the plan.

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**Limitations**

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in Section 441.169 when the case management activities are an integral and inseparable component of another Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial participation (FFP) is not available in expenditures for, services defined in Section 441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements (42 CFR 441.18(c)). First-time mothers who are in foster care or under the jurisdiction of the juvenile justice system or the criminal justice system will not be eligible for targeted case management services under this program.

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social educational or other program except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Act. (Sections 1902(a)(25) and 1905(c)).

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PACE Services

Name and address of State Administering Agency, if different from the State Medicaid Agency:

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I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

- A.  The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

**Institutionalized spouses under Section 1924 of the SSA**

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

- B.  The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - PACE Program Agreement)
- C.  The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

**Regular Post Eligibility**

1.  SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

State of New York

Supplement 3 to Attachment 3.1-A

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1. \_\_\_ The following standard included under the State plan (check one):

- (a) \_\_\_ SSI
- (b) \_\_\_ Medically Needy
- (c) \_\_\_ The special income level for the institutionalized
- (d) \_\_\_ Percent of the Federal Poverty Level: \_\_\_ %
- (e) \_\_\_ Other (specify): \_\_\_\_\_

2. \_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

3. \_\_\_ The following formula is used to determine the needs allowance:

\_\_\_\_\_  
\_\_\_\_\_

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

- 1. \_\_\_ SSI Standard
- 2. \_\_\_ Optional State Supplement Standard
- 3. \_\_\_ Medically Needy Income Standard
- 4. \_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

5. \_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_ % of \_\_\_ standard.

6. \_\_\_ The amount is determined using the following formula:

\_\_\_\_\_  
\_\_\_\_\_

7. \_\_\_ Not applicable (N/A)

(C.) Family (check one):

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**New**

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- 1.  AFDC need standard
- 2.  Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

- 3.  The following dollar amount: \$ \_\_\_\_\_  
Note: If this amount changes, this item will be revised.
- 4.  The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_ % of \_\_\_\_\_ standard.
- 5.  The amount is determined using the following formula:  
\_\_\_\_\_  
\_\_\_\_\_
- 6.  Other
- 7.  Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

- 2.  209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

- 1. Allowances for the needs of the:
  - (A.) Individual (check one)
    - 1.  The following standard included under the State plan (check one):
      - (a)  SSI
      - (b)  Medically Needy
      - (c)  The special income level for the institutionalized
      - (d)  Percent of the Federal Poverty Level: \_\_\_\_\_ %
      - (e)  Other (specify): \_\_\_\_\_

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2. \_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

3. \_\_\_ The following formula is used to determine the needs allowance:

\_\_\_\_\_  
\_\_\_\_\_

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1. \_\_\_ The following standard under 42 CFR 435.121:

\_\_\_\_\_

2. \_\_\_ The Medically needy income standard

\_\_\_\_\_

3. \_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

4. \_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_ % of \_\_\_\_\_ standard.

5. \_\_\_ The amount is determined using the following formula:

\_\_\_\_\_

6. \_\_\_ Not applicable (N/A)

(C.) Family (check one):

1. \_\_\_ AFDC need standard

2. \_\_\_ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. \_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

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4. \_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_% of \_\_\_ standard.

5. \_\_\_ The amount is determined using the following formula:  
\_\_\_\_\_  
\_\_\_\_\_

6. \_\_\_ Other

7. \_\_\_ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

**Spousal Post Eligibility**

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A). \_\_\_ The following standard included under the State plan (check one):

- 1. \_\_\_ SSI
- 2. \_\_\_ Medically Needy
- 3. \_\_\_ The special income level for the institutionalized
- 4. \_\_\_ Percent of the Federal Poverty Level: \_\_\_%
- 5. \_\_\_ Other (specify): \_\_\_\_\_

(B). X The following dollar amount: \$ 50\*

Note: If this amount changes, this item will be revised.

**\*For non-institutionalized participants, the PNA is equal to the difference between the amounts of the**

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**medical assistance eligibility standard for one person  
and two person households.**

(C)\_\_\_\_\_The following formula is used to determine the needs allowance:

\_\_\_\_\_

\_\_\_\_\_

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

**The amount for non-institutionalized participants is the same incremental difference used under the community eligible rules when a household of one increases to a household of two. The amount covers the additional cost for food, shelter and personal incidentals of a second individual in the household. Married couples not living together will be determined as individuals under the Medically Needy criteria.**

II. Rates and Payments

- A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

**Refer to Attachment 4.19-B, page 17**

1. \_\_\_\_\_ Rates are set at a percent of fee-for-service costs
2. \_\_\_\_\_ Experience-based (contractors/State's cost experience or encounter date)(please describe)

02-01

TN No.: \_\_\_\_\_  
Superseded  
TN NO.: **New**

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State of New York

Supplement 3 to Attachment 3.1-A

Page 7

3.      Adjusted Community Rate (please describe)  
4. X Other (please describe)

Refer to Attachment 4.19-B, page 17

- B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.
- C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

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**02-01**

**New**

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SUBPART 86-1  
MEDICAL FACILITIES

(Statutory authority: Public Health Law, 2803, 2807, 2807-a,  
2807-c, 2808-c, 3612; L. 1983, ch. 758, 7)

Sec.	
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86-1.41	(Reserved)
86-1.42	Hospital-based physician reimbursement program
86-1.43	(Reserved)
86-1.44	(Reserved)
86-1.45	Federal financial participation
86-1.46	(Reserved)
86-1.47	(Reserved)
86-1.48	(Reserved)
86-1.49	(Reserved)

TN 92-26 Approval Date MAY 19 1993  
Supersedes TN 88-6 Effective Date APR 1 - 1992

APPENDIX II

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF NEW YORK

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

INPATIENT HOSPITAL CARE

10 N.Y.C.R.R. PART 86-1

\*Mandated Federal Reference

Approved Date JUL 23 1987

Effective Date 1987

85-34

PrefaceGeneral Reimbursement Provisions

On January 1, 1988 the New York State Department of Health implemented a new Medicaid reimbursement methodology for hospitals utilizing case based rates of payment. This was a departure from the per diem methodology whereby hospitals received the same dollar amount per inpatient day of care regardless of the services rendered. The new system is more reflective of the amount of services rendered to each patient and makes a lump sum payment to the hospital based in part on an average per case cost of a hospital's peer group and the actual services that a particular patient receives during the inpatient stay.

This major change in reimbursement policy led to a change in the way methodology and rate changes are implemented since a portion of the rate is now based on a group average price. To stabilize the group price and hospital rates, the Department of Health calculates two rate changes per year, January 1 and July 1. However, the Department still makes modifications to the Medicaid State Plan for inpatient hospital reimbursement on a quarterly basis to reflect changes in the rate calculation methodology. Generally, the State Plan amendments effective in the second and fourth quarter of each year and on other than the first day of the first and third quarter of each year are prospectively implemented in inpatient hospital rates on the next rate calculation date of July 1 or January 1, unless otherwise noted in the State Plan or unless the prospective adjustment would seriously impact a general hospital's financial stability. Initial rate adjustments related to such amendments will be increased or decreased to take into account the effective period prior to the rate cycle.

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New York  
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86-1.1 (88-6)  
Attachment 4.19-A  
Part I

86-1.1 [Definitions.] Reserved

TN 88-6 Approval Date AUG 1 1991  
Supersedes TN 85-34 Effective Date JAN 01 1988

New York  
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86-1.2 (88-6)  
Attachment 4.19-A  
Part I

86-1.2 [Medical facility rates.] Reserved

TN 88-6 Approval Date AUG 1 1981

Supersedes TN 85-34 Effective Date JAN 01 1980

86-1.3 Financial and statistical data required. (a) Each medical facility shall complete and file with the New York State Department of Health and/or its agent annual financial and statistical report forms supplied by the department and/or its agent. Medical facilities certified for title XVIII (Medicare) shall use the same fiscal year for title XIX (Medicaid) and title B (children's bureau programs) as is used for title XVIII. All medical facilities must report their operations from January 1, 1977 forward on a calendar-year basis.

(b) Financial and statistical reports required by this Subpart shall be submitted to the department and/or its agent no later than 120 days following the close of the period. Extensions of time for filing reports may be granted by the commissioner upon application received prior to the due date of the report only in those circumstances where the medical facility establishes, by documentary evidence, that the reports cannot be filed by the due date for reasons beyond the control of the facility.

(c) In the event a medical facility fails to file the required financial and statistical reports on or before the due dates, or as the same may be extended pursuant to subdivisions (b) or (e) of this section, or fails to comply with the provisions of section 86-1.6 of this Subpart, the State Commissioner of Health shall reduce the current rate paid by governmental agencies by two percent for a period beginning on the first day of the calendar month following the original due date of the required reports and continuing until the last day of the calendar month in which said required reports are filed.

(d) In the event that any information or data which a facility has submitted to the Department of Health on required reports, budgets or appeals for rate revisions intended for use in establishing rates is inaccurate or incorrect, whether by reason of subsequent events or otherwise, such facility shall forthwith submit to the department a correction of such information or data which meets the same certification requirements as the document being corrected.

(e) If the financial and statistical reports required by this Subpart are determined by the department or its agent to be incomplete, inaccurate or incorrect, the facility will have 30 days from date or receipt of notification to provide the corrected or additional data. Failure to file the corrected or additional data that was previously required within [that period] 30 days, or within such period as extended by the Commissioner, will result in application of subdivision (c) of this section.

(f) Data required to be filed with the department pursuant to section 400.18(b) of this Title shall be submitted according to the specified format for at least 80 percent of all discharged patients within 60 days from the end of the month of patient billing and for at least 100 percent of all patients discharged during the hospital's twelve month fiscal reporting period within 120 days from the end of the hospital's fiscal year reporting period. Where the 80 percent criterion is not met for a given quarter, the provisions of subdivision (c) of this section shall apply, except where the facility demonstrates that the delay in submission of the data is beyond its control.

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 OCT 1 - 1992  
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 TN 92-46  
 Supersedes TN 92-06

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86-1.3(3/94)  
Attachment 4.19-A  
Part I

~~{Where the 100 percent criterion is not met for the given twelve-month fiscal period, the commissioner shall notify the facility and the facility shall, within 180 days from the end of the hospital's fiscal year reporting period, meet the 100 percent criterion. If the 100 percent criterion is not then met, the provisions of subdivision (c) of this section shall apply, except where the facility demonstrates that the delay in submission is beyond its control.}~~

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Supersedes TN \_\_\_\_\_ Effective Date JAN 01 1994

(g) ~~{Data required to be filed with the department pursuant to section 400.19(e) of this Title shall be submitted according to the specified format for at least 95 percent of all discharged patients within 60 days from the end of the month of patient discharge. Where in each of two successive quarters this criterion is not met, the provisions of subdivision (e) of this section shall apply, except where the facility demonstrates that the delay in submission of the data is beyond its control. Such data shall be submitted according to the specified format for at least 95 percent of all patients discharged during the hospital's twelve month fiscal reporting period within 120 days from the end of that fiscal reporting period. Where this criterion is not met for the given fiscal period, the provisions of subdivision (e) of this section shall apply, except where the facility demonstrates that the delay in submission of the data is beyond its control.}~~  
Reserved

(h) Specific additional data related to the rate setting process may be requested by the State Commissioner of Health. These data, which may include but are not limited to those for use in a wage geographic differential survey, a peer grouping data survey, a medical supplies survey, a malpractice insurance survey, a graduate medical education survey, and a quarterly utilization survey must be provided by the medical facility within 30 days from the date of receipt of notification to supply such information. The commissioner must supply to each facility, prior to the start of each rate period, a preliminary listing of the data that will be required. Failure to submit the additional data shall result in

TN 94-06      Renewal Date \_\_\_\_\_  
Supersedes 92-06      JAN 01 1994

rate in accordance with] application of the provisions of subdivision (c) of this section, unless the medical facility can prove by documentary evidence that the data being requested is not available.

(i) General hospitals shall submit to the commissioner at least 120 days prior to the commencement of each revenue cap year, a schedule of anticipated capital-related inpatient expenses for the forthcoming year pursuant to the provisions of section 86-1.30 of this Subpart.

(j) General hospitals shall submit to the Commissioner of Health a report of hospital expenses incurred in providing services during the period covered by the reports required under this section for which payment was not received and is not anticipated. The report shall be completed in accordance with definitions of bad debt and charity care found in section 86-1.11 of this Subpart. The report shall identify as bad debts or charity care the cost of services provided to emergency inpatients, nonemergency inpatients, emergency ambulatory patients, clinic patients and referred or private ambulatory patients for which the hospital did not receive and does not anticipate payment.

(k) Medical facilities shall submit to the Commissioner of Health discrete financial and statistical data for medical/surgical services, maternity services, pediatric services, normal newborns, premature newborns, psychiatric services, intensive care services, coronary care unit and other intensive care-type inpatient hospital units, and statistical data for alternate level of care services.

TN 92-06

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86-1.3 (3/92)  
Attachment 4.19-A  
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(1) General hospitals with exempt psychiatric units shall submit hospital data regarding patients in such units as required by the Office of Mental Health.

(m) Each medical facility shall file with the New York State Department of Health a complete copy of the Department of the Treasury, Internal Revenue Service Form 990, for that facility. The Form 990 shall be submitted to the department no later than 30 days following the annual filing with the Internal Revenue Service. Failure to submit the Form 990 shall result in application of the provisions of subdivision (c) of this section.

TN 92-06 <sup>1</sup>  
Supersedes TN New Approval Date OCT 18 1993  
Effective Date MAR 11 1992

Section 86-1.4 Uniform system of accounting and reporting. (a)  
Medical facilities shall maintain their records in accordance with:

- (1) section 405.23 of Article 2 of Subchapter A of Chapter V of this Title; and
- (2) Article 8 of Subchapter A of Chapter V of this Title.

(b) Rate schedules shall not be certified by the Commissioner of Health unless medical facilities are in full compliance with reporting requirements of this Subpart and section 405.23 of this Title.

(c) For purposes of rate setting, medical facilities shall submit to the New York State Department of Health, or its authorized agent, a certified uniform financial report and a uniform statistical report in accordance with the policies and instructions as set forth in section 405.23(b) of Article 2 of Subchapter A of Chapter V of this Title.

(d) The institutional cost report and supplementary schedule form as adopted by the department shall be used to report financial and statistical data for 1981 in order to establish rates of payment for title 19 providers in 1983.

(e) Failure of a medical facility to file the reports required pursuant to this section will subject the medical facility to a rate reduction as set forth in section 86-1.3 of this Subpart.

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Effective Date JAN. 1 1986

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Section 86-1.5 Generally accepted accounting principles. The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the medical facility, unless the reporting instructions authorize specific variation in such principles.

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Section 86-1.6 Accountant's certification. (a) The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant. The minimum standard for the term independent shall be the standard used by the State Board of Public Accountancy.

(b) The requirements of subdivision (a) of this section shall apply to medical facilities operated by units of government of the State of New York heretofore exempt from the requirements of this section. Certification of reports from these facilities will be required effective with report periods beginning on or after January 1, 1977.

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Attachment 4.19-A  
Part I

Section 86-1.7 Certification by operator, officer or official.

(a) The financial and statistical reports shall be certified by the operator of a proprietary medical facility, an officer of a voluntary medical facility, or the public official responsible for the operation of a public medical facility.

(b) The form of the certification required in subdivision (a) of this section shall be as prescribed in the annual fiscal and statistical report forms provided by the State Commissioner of Health.

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Attachment 4.19-A  
Part I

**Section 86-1.8 Audits.** (a) All fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports, filed by the medical facility with the department, shall be kept and maintained by the facility for a period of time not less than six years from the date of filing or the date upon which the fiscal and statistical records were to be filed, whichever is the later date. In this respect, any rate of payment certified or established by the State Commissioner of Health prior to audit shall be construed to represent a provisional rate until such audit is performed and completed, at which time such rate or adjusted rate will be construed to represent the audited rate.

(b) Subsequent to the filing of fiscal and statistical reports, field audits shall be conducted of the records of medical facilities in a time, manner and place to be determined by the State Department of Health. Where feasible, the department shall enter into an agreement to use a combined audit (Medicare/Medicaid and other organizations and agencies having audit responsibilities) to satisfy the department's auditing needs. In this respect, the State Department of Health reserves the right, after entering into an agreement to use a combined audit, to reject the audit findings of other organizations and agencies having audit responsibilities and to perform a limited scope or comprehensive audit of their own for the same fiscal period audited by the organization and/or agency.

(c) The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department or from the date when due, whichever is later. This limitation shall not apply to situations in which fraud may be involved, or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this section.

(d) Upon completion of the audit, the medical facility shall be afforded a closing conference. The medical facility may appear in person or by anyone authorized in writing to act on behalf of the medical facility. The medical facility shall be afforded an opportunity at such conference to produce additional documentation in support of any modifications requested in the audit.

(e) The medical facility shall be provided with the audit report and the rate computation sheet per audit. The audit report shall be final unless within 30 days of receipt of the audit report, the medical facility initiates a bureau review of such final audit report by notifying the Division of Health Care Financing by registered or certified mail, detailing the specific items of the audit report with which the provider disagrees, and such other material as the provider wishes to submit in its behalf, and forwarding all material documentation in support of the medical facility's position.

(f) The medical facility shall be notified in writing of the determination of the controverted items of the final audit report, including a statement of the reasons for such adjustments and the appropriate citation to applicable law, regulation or policy. The audit

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findings as adjusted in accordance with the determination of the bureau review shall be final, except that the medical facility may, within 30 days of receipt of the determination of the bureau review, initiate a hearing to refute those items of the audit report adverse to the interests of the medical facility presenting a factual issue by serving on the commissioner, by certified or registered mail, a notice containing a statement of the legal authority and jurisdiction under which the hearing should be held, a reference to the particular sections of the statutes and rules involved and a statement of the controverted items of the audit report and bureau determination, together with copies of any documentation relied on by the medical facility in support of its position.

(1) Upon receipt of such notice the commissioner shall:

(i) designate a hearing officer to hear and recommend;

(ii) establish a time and place for such hearing;

(iii) notify the medical facility of the time and place of such hearing at least 15 days prior thereto; and

(iv) include in a notice of hearing those issues of the audit report which are controverted in the notice served on the commissioner by the medical facility.

(2) The issues and documentation presented by the medical facility at such hearing shall be limited to the factual issues and documentation presented at the bureau review.

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(3) The audit report shall be presumptive evidence of its content. The burden of proof at any such hearing shall be upon the medical facility to prove by substantial evidence that the items therein contained are incorrect.

(4) The hearing shall be conducted in conformity with section 12-a of the Public Health Law and the State Administrative Procedure Act.

(5) At the conclusion of the hearing the medical facility may submit memoranda on any legal issues which it deems relevant to the proceeding. Such memoranda shall become part of the official record of the hearing.

(g) Rate revisions resulting from the procedure set forth in this section shall be made retroactive to the period or periods during which the rates based on the periods audited were established. Any resulting overpayment or underpayment shall be satisfied by either retroactive adjustment of the provisional rate paid, based on the period audited, or prospective adjustment of the current certified rate at the discretion of the State Commissioner of Health.

(h) [All overpayments resulting from rate revisions shall be subject to such penalties as the Commissioner of Health may impose for

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the incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions. The penalties assessed under this section are separate from and shall not be construed to be in mitigation of damages which may be recovered pursuant to section 145-b of the Social Services Law.] reserved.

(i) Notwithstanding the provisions of this section, the commissioner may promulgate rate revisions based on audits completed by another State agency. Unless otherwise indicated, such audits shall not be considered final and shall not preclude conduct of a complete audit by the State Department of Health or its agent.

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Section 86-1.9 Patient days. (a) A patient day is the unit of measure denoting lodging provided and services rendered to one inpatient ~~between the census taking hour on two successive days.~~

(b) In computing patient days, the day of admission shall be counted but not the date of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes, three newborn days shall be reported as the equivalent of one adult or child day. The following types of care shall not be treated as being rendered to newborns for patient day calculations: premature infant, newborn remaining in hospital after mother's discharge, sick infant care requiring general hospital service, and infant care to those born outside the hospital and not placed in the newborn nursery.

(d) For reimbursement purposes, patient days for medical/surgical, pediatrics, and maternity shall be computed as follows:

(1) Medical-surgical patient days for facilities located in counties having an average population density of 100 or more persons per square mile shall be determined by using the higher of the minimum utilization factor of 85 percent of certified beds or actual patient days of care furnished by the facility. Medical-surgical patient days for facilities located in counties having an average population density of less than 100 persons per square mile shall be determined by using the higher of the minimum utilization factor of 80 percent of certified beds or actual patient days of care furnished by the facility.

(2) Pediatric patient days shall be determined by using the higher of the minimum utilization factor of 70 percent of certified beds or actual patient days of care furnished by the facility.

(3) Maternity patient days for facilities located in areas having a plan approved by the commissioner for the regionalization of obstetrical service, and subsequent to January 1, 1978 for all facilities including those services in areas not having an approved plan shall be determined as follows:

(i) Maternity patient days for facilities in counties with an average population density of 100 or more persons per square mile shall be determined by using the lower of the minimum utilization factor of 75 percent of certified beds or, if the facility generated less than 1,500 live births, the difference between 1,500 and the actual number of live births generated by the facility multiplied by the average length of stay for a maternity patient plus the actual days of care furnished by the facility or, if the facility generated more than 1,500 live births, the actual days of care furnished by the facility.

(ii) Maternity patient days for facilities in counties with an average population density of less than 100 persons per square mile shall be determined by using the lower of the minimum utilization factor of 60 percent of certified beds or, if the facility generated less than 500 live births, the

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difference between 500 and the actual number of live births generated by the facility multiplied by the average length of stay for a maternity patient plus the actual days of care furnished by the facility or if the facility generated more than 500 live births, the actual days of care furnished by the facility.

(iii) Maternity service patients for purpose of computations pursuant to subparagraphs (i) and (ii) of this paragraph shall include obstetrical and gynecological patients housed in the maternity unit.

(4) The provisions of paragraphs (1) and (2) of this subdivision shall be waived in total or in part by the Commissioner of Health in those cases where waiver has been demonstrated to be a matter of public interest and necessity. Where a facility could reach its minimum utilization factor by reducing the certified bed capacity by more than five beds or one percent of its certified bed complement, whichever is greater, the commissioner may grant a waiver only if the facility decertifies the total number of beds necessary to reach the minimum utilization factor. Where the minimum bed utilization factor would be reached by decertifying no greater than five beds or one percent of its certified bed complement, a waiver shall be granted and decertification of beds shall not be required.

(5) The provisions of paragraph (3) of this subdivision shall be waived by the Commissioner of Health in those cases wherein there is an approved regional plan and wherein the service in question, its capacity and operation are consistent with the approved regional plan. The provisions of paragraph (3) of this subdivision may be waived by the commissioner where it is a matter of public interest and necessity; if such a waiver is granted, maternity patient days shall be determined by using the higher of the applicable minimum utilization factor or live birth formula as set forth in paragraph (3) of this subdivision.

(6) The provisions of paragraphs (1) - (3) of this subdivision shall be waived for rural hospitals as defined in this Title.

(7) No waiver pursuant to this subdivision shall be granted for periods predating the first day of the month following 30 days after receipt by the commissioner of the request and justification for the waiver, and fulfillment of conditions to the waiver, where such conditions exist.

(e) For reimbursement purposes, patient days for open heart surgery, cardiac invasive diagnostic procedures and kidney transplants shall be computed as follows for those facilities engaged in such operations or procedures:

(1) Patient days for any facility engaged in performing open heart surgery and carrying out less than 100 adult and/or 50 pediatric (less than age 21) operations during the reporting period shall be increased by an amount equal to the average length of stay for the adult and/or pediatric open heart surgery cases multiplied by the difference between 100 adult or 50 pediatric and

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the actual number of adult or pediatric open heart surgery operations carried out by the approved cardiac surgical center as referenced in Part 405 of this Title.

(2) Patient days for any facility engaged in performing adult or pediatric (less than 21) cardiac invasive diagnostic procedures and carrying out less than 200 adult and/or 100 pediatric procedures during the reporting period shall be increased by an amount equal to the average length of stay for the adult or pediatric procedures multiplied by the difference between 200 adult and/or 100 pediatric cardiac invasive diagnostic procedures and the actual number of procedures carried out by the approved cardiac diagnostic center as referenced in Part 405 of this Title.

(3) Patient days for any facility engaged in kidney transplants and carrying out less than 25 such transplants during a reporting period shall be increased by an amount equal to the average length of stay for kidney transplants multiplied by the difference between 25 and the actual transplants carried out by the facility.

The provisions of this subdivision may be waived by the State Commissioner of Health upon application by the health facility in those cases where waiver is found to be a matter of public interest and necessity. No waiver shall be granted for periods predating the first day of the month following 30 days after receipt by the commissioner of request and justification for the waiver.

(f) Patient days for all alternate level of care (ALC) services shall be reported separately. Patient days for alternate level of care services shall be utilized in the determination of minimum utilization standards as set forth in section 86-1.9(d) of this Subpart.

(g) For rate year 1985 hospitals located in an HSA region where the average daily medical/surgical occupancy is less than the appropriate minimum utilization factor set forth in paragraph (1) of subdivision (d) of this section and the hospital itself has an average daily medical/surgical occupancy of less than the appropriate minimum utilization factor set forth in paragraphs (1) and (4) of subdivision (d) of this section and the hospital provides alternate level of care services, the hospital's title XIX rate shall be reduced by the difference between its title XIX rate and the facility's allowable routine cost as determined pursuant to this Subpart and a statewide average of allowable ancillary costs for hospital-based skilled nursing or health related facilities, as appropriate to the level of care actually provided to the patient and as determined pursuant to Subpart 86-2 of this Title. Beds for which a facility has applied for decertification by January 31, 1986 and which are decertified by the commissioner shall not be counted in the calculation of occupancy rates for the purposes of this subdivision. The provisions of this subdivision shall be waived for hospitals which in 1985 meet the definition of rural hospital set forth in section 405.2(m) of this Title and which are not identified as unnecessary in the state and regional medical facilities plan established pursuant to section 710.13 of this Title.

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Section 86-1.10 Effective period of reimbursement rates. Certification of reimbursement rates of payment by governmental agencies shall be for a 12-month calendar year period or for such other period as may be prescribed. Certification of reimbursement rates by article IX-C corporations shall be for the periods specified in the reimbursement formula approved by the Commissioner of Health.

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## Section 86-1.11 Computation of basic rate.—

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(b) Payment rates for the period January 1, 1983 through December 31, 1983 shall be established on a prospective basis. Such payments shall be computed on the basis of allowable historical inpatient expense based on the fiscal and statistical data submitted by the medical facility for the fiscal year ended at least six months prior to January 1, 1983 and upon the data described below. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days, except as stated in subdivision (1) of this section and section 86-1.41 of this Subpart. Total allowable costs of a facility shall be apportioned among beneficiaries of programs administered under titles XVIII and XIX of the Federal Social Security Act and article IX-C of the New York State Insurance Law and other patients, so that the share borne by each program is based upon actual services received by that program's beneficiaries. To accomplish this apportionment, for each program the ratio of beneficiary charges to total patient charges for the services of each ancillary department shall be applied to the cost of the department; to this shall be added the cost of routine services for program beneficiaries, determined on the basis of an average cost per diem.

(1) Hospitals with charge structures from which an apportionment of costs cannot be determined will be paid only on the basis of total average cost per diems, unless the hospital can provide adequate and verified statistical data to apportion ancillary costs among beneficiaries.

(2) After July 1, 1984 the apportionment computed in this section will be revised to reflect 1982 charge data and patient day data received by the Commissioner pursuant to section 86-1.3 of this Subpart.

(3) In 1983, costs of malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned among programs on the basis of average cost. In 1984 and 1985, one-third and two-thirds, respectively, of malpractice costs will be apportioned on the basis of payor experience. Apportionment on the basis of experience shall be based on the dollar ratios for each payor of the facility's malpractice losses paid by that payor to its total paid malpractice losses for the current cost reporting period and the preceding four-year period. If a facility has no malpractice loss experience for the five-year period, the costs of malpractice insurance premiums or self-insurance fund contributions must be apportioned among the programs based on the national ratio of malpractice awards paid to program beneficiaries to malpractice awards paid to all patients. If a facility pays allowable uninsured malpractice losses incurred by program beneficiaries, either through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as

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a governmental provider, such losses and related direct costs must be directly assigned to a respective program for reimbursement.

(c) (1) To the allowable basic rate, computed in accordance with ceiling limitations and to the discrete alternate level of care rate if applicable, and prior to the addition of capital costs (depreciation, leases and interest), there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. This factor shall be developed in accordance with section 86-1.15 of this Subpart. The allowances specified in subdivisions (e)-(g) of this section shall be computed on the basis of, and added to, the trended basic rate plus capital costs.

(2) reserved

(d) General hospital inpatient revenue cap. (1) An inpatient revenue cap for each general hospital for each of the rate years 1984 and 1985 shall be established as follows and shall include only the revenues set forth below. An initial inpatient revenue cap shall be calculated for each general hospital by first trending to each rate year the allowable historical inpatient operational expenses reimbursed in 1983. The initial allowable historical inpatient operational expenses to be trended shall reflect all closed appeals and audit adjustments pursuant to this Subpart. The trend factors used shall be developed in accordance with section 86-1.15 of this Subpart. The following revenues shall then be added to trended allowable historical inpatient operational expenses for each rate year:

(i) capital related inpatient expenses determined in accordance with sections 86-1.29 and 86-1.30 of this Subpart;

(ii) the allowances provided for in subdivisions (e)-(g) of this section, calculated for each rate year utilizing the sum of trended allowable historical inpatient operational expenses and capital related inpatient expenses; and

(iii) any anticipated additional revenues generated by a general hospital's charge schedule, developed in accordance with section 86-1.2 of the Subpart, for each respective rate year.

(2) The initial revenue caps for rate years 1984 and 1985 shall be adjusted to reflect the following:

(i) case mix changes pursuant to the provisions of subdivision (s) of this section and volume changes;

(ii) appeals filed and/or adjustments made pursuant to sections 86-1.16 and 86-1.17 of this Subpart; and

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(iii) any adjustments made in payments under title XVIII of the Federal Social Security Act (Medicare) pursuant to section 86-1.43 of this Subpart.

(3)(i) The commissioner shall require direct repayment or adjust a subsequent year's inpatient revenue cap to reflect actual inpatient revenues received for inpatient services provided by a general hospital that exceed a previous year's inpatient revenue cap initially established or adjusted in accordance with this Subpart. A general hospital determined to have such excess revenues shall be subject to direct repayment or adjustment of a subsequent revenue cap when such excess is due to establishment of a charge schedule that is not in compliance with section 86-1.2(c) of this Subpart. Revenue received established as a result of the provisions of title XVIII of the Federal Social Security Act (Medicare) phase-in policies or from charges authorized under section 86-1.17(h) of this Subpart in excess of the revenue cap shall not be included in the adjustment.

(ii) A facility that maintains charge schedules less than the maximums set forth in section 86-1.2(c) of this Subpart such that it results in it receiving less than the maximum allowable charge paying rate shall not be compensated by other payors for the amount by which its charge revenues are less than the maximum amount allowed.

(4) That portion of the revenue cap that is related to utilization of inpatient services shall be apportioned among beneficiaries of programs administered under titles XVIII and XIX of the Federal Social Security Act and article IX-C of the New York State Insurance Law, and those enrolled in organizations operating in accordance with the provisions of article 44 of the Public Health Law, so that the share borne by each program is based upon actual services received by that program's beneficiaries. To accomplish this apportionment, for each ancillary department, the ratio of total department costs to total department charges will be applied to program beneficiary charges for the services of that ancillary department to develop an ancillary cost per day for beneficiaries of that program; to this shall be added the cost of routine services for program beneficiaries, determined on the basis of an average cost per diem.

(i) Any adjustment in the overall revenue cap in accordance with this Subpart shall be reflected in an appropriate adjustment to this portion of the revenue cap and payment levels by these programs.

(ii) After such adjustments, the portion of the revenue cap initially established, or as adjusted, that is related to the actual utilization of covered inpatient services of the above programs, shall constitute guaranteed revenue to the general hospital.

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(iii) Hospitals with charge structures from which an apportionment of costs cannot be determined will be paid only on the basis of total average cost per diem, unless the hospital can provide adequate and verified statistical data to apportion ancillary costs among beneficiaries.

(e) reserved

(f) reserved

(g) Bad debt and charity care regional pools and allowances. Regional pools will be established from which allowances will be added to hospital rates to help pay for the costs of bad debt and charity care for the three year period commencing January 1, 1983, and ending December 31, 1985. Such pools shall receive funds from hospitals pursuant to this subdivision and section 86-1.37 of this Subpart. For the rates established in 1983, the resources available for purposes of establishing the bad debt and charity care pools shall be calculated on the basis of two percent of the total statewide general hospital (including both major public hospitals and all other hospitals) reimbursable inpatient operating costs after application of the trend factor plus the addition of capital costs. For the rates established in 1984 and 1985, the resources available for establishing these pools shall be calculated on the basis of three percent and four percent, respectively of total statewide general hospital reimbursable inpatient operating costs in the respective rate year after application of the trend factor plus the addition of capital costs.

(1) To be eligible to receive an allowance from the bad debt and charity care pool funded by paragraph (4) of this subdivision and the financially distressed hospital pool funded by subdivision (g)(8) of this section, a facility must meet the following criteria. Compliance with these criteria shall be subject to audit.

(i) The costs of bad debt and charity care must be determined according to the following definitions and must be reported in the appropriate sections of the facility's Institutional Cost Report.

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(a) Bad debt. Bad debts are the amounts which are considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services, and are collectable in money in the next operating cycle. Bad debts shall be determined in accordance with generally accepted accounting principles which recognize the direct charge-off method, the reserve method, or a combination of the direct charge-off method and the reserve method. Additionally, the debt must be related to a service which the facility has been authorized by the commissioner to provide. If an amount previously written off as a bad debt is recovered in a subsequent accounting period, the amount written off must be used to reduce the cost of bad debt for the period in which the collection is made.

(b) Charity care. Charity care is the reduction in charges made by the provider of services because the patient is indigent or medically indigent. Reductions in charge for employees which are accounted for as fringe benefits, such as hospitalization and personnel health programs, are not considered charity care. Courtesy allowances, such as free or reduced-charge services provided to other than the indigent or medically indigent, are not considered charity care.

(ii) The facility must maintain reasonable collection efforts and procedures.

(a) The hospital must utilize commonly accepted business methods and practices to collect unpaid amounts from all classes of payors. Such methods may differ for inpatient and outpatient services. The hospital shall utilize good business judgment and practices in determining the amounts to be collected.

(b) The hospital must determine the patient's ability to pay for the services rendered and document the method under which the determination was made.

(c) The hospital must generate and maintain written documentation of requests for payment for services provided.

(d) The hospital must take any subsequent actions as appropriate within good business practice such as subsequent billings, collection letters or telephone calls. These subsequent actions must be documented.

(e) The hospital may turn accounts over to a collection agency. Amounts so turned over may be written off as a bad debt at the time of turnover. Amounts collected by the facility after write-off

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constitute a recovery of bad debts in the period collected.

(f) The hospital shall not be required to pursue judgment claims before the account can be written off.

(g) A policy which is consistent and follows commonly accepted business methods and practices concerning the time period that must elapse between initial billing and the determination that an unpaid bill is a bad debt must be maintained from January 1, 1981 to December 31, 1985. A finding of inconsistency may be waived upon demonstration by the facility that a policy change served to make bad debt determination policies consistent with the requirements of this subdivision.

(iii) The facility shall submit by October 1, 1983 and thereafter within 120 days from the beginning of a rate year, a report containing an opinion by its independent certified public accountant or independent licensed public accountant in a form approved by the commissioner after consultation with the New York State Society of Certified Public Accountants, as to whether the facility meets the criteria of this subdivision for eligibility for a distribution from the bad debt and charity pool. The commissioner may accept a report containing an opinion that the facility is in compliance with the criteria of this subdivision as establishing initial eligibility as of the first day of each rate year for distribution from the pool. Thereafter if the commissioner determines that the facility is not in compliance, such noncompliance shall be applicable for the entire rate year. The facility may appeal this noncompliance determination pursuant to the provisions of section 86-1.17(i) of this Subpart. If the facility chooses to appeal the commissioner's determination, the facility will continue to receive payments from its regional pools, if otherwise eligible, until a final determination has been made. If it is finally determined that the facility is not in compliance or if the facility chooses not to appeal the commissioner's determination that it is out of compliance, the facility shall repay to its regional pools all monies received from these pools for the period during which it was out of compliance. If a facility fails to repay such monies to its regional pools within a reasonable period of time, major third-party payors shall adjust the facility's rate as directed by the commissioner to reflect money owed to the pools and shall pay these monies to the pool administrator.

(2) For the purposes of this subdivision only, the following words or phrases shall be defined as follows:

(i) Major public sector shall mean all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospitals Corporation as established in chapter 1016 of the Laws of 1969, as amended and all other

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public general hospitals having annual inpatient operating costs in excess of \$25 million.

(ii) Voluntary sector shall mean all voluntary nonprofit, private proprietary and public general hospitals other than major public general hospitals.

(3) reserved

(4) reserved

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Reserved

(g)(5) reserved

(g)(6) reserved

(g)(7) reserved

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(8) reserved

(g)(9) reserved

(h) reserved

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(1)(1) reserved

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(1)(2) reserved

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(m) Payment rates for the periods January 1, 1986 through December 31, 1986 and January 1, 1987 through December 31, 1987 shall be established on a prospective basis and shall be based on the reimbursable operating costs used in determining payments for services provided during 1985. Such costs shall include the annualized cost impact of rate revisions or adjustments made with respect to such services. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days, except as stated in

section 86-1.41 of this Subpart.

(1) Total allowable costs of a facility shall be apportioned among beneficiaries of programs administered under titles XVIII and XIX of the federal Social Security Act and article 43 of the New York State Insurance Law and other patients, so that the share assigned to each program is based upon actual services received by that program's beneficiaries. To accomplish this apportionment, for each program the ratio of beneficiary charges to total patient charges for the services of each ancillary department shall be applied to the cost of the department; to this shall be added the cost of routine services for program beneficiaries, determined on the basis of an average cost per diem. This apportionment shall be based on 1984 data. Hospitals with charge structures from which an apportionment of costs cannot be determined will be paid only on the basis of total average cost per diems, unless the the hospital can provide adequate and verified statistical data to apportion ancillary costs among beneficiaries.

(2) The costs of malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned among programs on the basis of payor experience. Apportionment on the basis of experience shall be based on the dollar ratios for each payor of the facility's malpractice losses paid by that payor to its total paid malpractice losses for the 1984 cost reporting period and the preceding four-year period. If a facility has no malpractice loss experience for the five-year period, the costs of malpractice insurance premiums or self-insurance fund contributions must be apportioned among the programs based on the statewide ratio of malpractice awards paid to program beneficiaries to malpractice awards paid to all patients. If a facility pays allowable uninsured malpractice losses incurred by program beneficiaries, either through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, such losses and related direct costs must be directly assigned to a respective program for reimbursement.

(3) reserved

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(4) To the allowable basic rates, computed in accordance with ceiling limitations and prior to the addition of a factor for capital costs, there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. This factor shall be developed in accordance with section 86-1.15 of this Subpart. The allowances specified in subdivisions (p) and (q) of this section shall be computed on the basis of, and added to, the trended basic rate plus capital costs.

(5) Adjustments to rates shall be made to reflect case mix and volume changes and appeals filed and/or adjustments made pursuant to this Subpart.

(n)(1) reserved

(2) reserved

(3) reserved

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(o) reserved

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(p) Regional pools in 1986 and 1987: bad debt and charity care. Regional pools will be established from which allowances will be added to hospital rates to help pay for the costs of bad debt and charity care for the rate years 1986 and 1987. Such pools shall receive funds from hospitals pursuant to the provisions of this subdivision and section 86-1.37 of this Subpart. For the rates established in 1986 and 1987, the resources available for the purposes of establishing the bad debt and charity care pools shall be calculated on the basis of four and one-half percent of the total statewide general hospital (including both major public hospitals and all other hospitals) reimbursable inpatient costs after application of the trend factor excluding inpatient costs related to services provided to beneficiaries of subchapter XVIII of the federal Social Security Act, and inpatient uncollectible amounts.

(1) To be eligible to receive an allowance from the bad debt and charity care pool funded by paragraph (4) of this subdivision and the financially distressed hospital pool funded by subdivision (q) of this section, a facility must meet in 1986 and 1987 the criteria specified in paragraphs (1) and (2) of subdivision (g) of this section with the following exception: a policy which is consistent and follows commonly accepted business methods and practices concerning the time period that must elapse between initial billing and the determination that an unpaid bill is a bad debt must be maintained from January 1, 1981 to December 31, 1987. Compliance with these criteria shall be subject to audit.

(2) For the purpose of this subdivision only, the following words or phrases shall be defined as follows:

(i) Major public sector shall mean all State-operated general hospitals, all general hospitals operated by the New

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York City Health and Hospitals Corporation as established by chapter 1016 of the Laws of 1969, as amended, and all other public general hospitals having annual inpatient operating costs in excess of \$25 million.

(ii) Voluntary sector shall mean all voluntary nonprofit, private proprietary and public general hospitals other than major public general hospitals.

(3) Hospital need shall be calculated pursuant to the provisions of paragraph (3) of subdivision (g) of this section.

(4) reserved

(p)(5) reserved

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(p)(6) reserved

(p)(7) reserved

(q) reserved

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(r) reserved

(s) a case mix adjustment to general hospitals' rates of payment and revenue caps shall be made in 1984 and 1985 and to general hospitals' rates of payment in 1986 and 1987 according to the provisions of this subdivision.

(1) For 1984 and 1985, a hospital shall have its case mix changes from 1981 to the appropriate rate year calculated on the basis of the patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.3 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights (SIWs) developed by the department, and diagnosis related group (DRGs). (The SIWs are the relative cost weights established by the department for DRGs such that the SIW for any given DRG indicates how expensive the average patient is in those DRGs compared to the average patient in all DRGs). The operating cost per day SIWs shall be all-payor SIWs.

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(2) For 1986 and 1987, a hospital shall have its case mix changes from the previous rate year to the appropriate rate year calculated on the basis of the non-Medicare patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.2 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights (SIWs) developed by the department and diagnosis related groups (DRGs). The operating cost per day SIWs shall be non-Medicare payor SIWs.

(3) [In 1984 and 1985, hospitals] Hospitals whose case mix as measured according to the provisions of [paragraph] paragraphs (1) and (2) of this subdivision increased by an amount less than or equal to 1 percent but did not decrease by an amount greater than [or equal to] 2 percent shall not receive any adjustment. Hospitals whose case mix increased by more than 1 percent [or more] or decreased by more than 2 percent [or more] shall receive an adjustment to their operating rates of payment and revenue caps pursuant to the provisions of paragraph (5) (4) of this subdivision.

[(3) For 1986, a hospital shall have its case mix change from 1985 to 1986 calculated as follows:

(i) The department shall evaluate all hospitals' patient discharge data used as the basis upon which the hospital's case mix change is calculated for the percentage of patient records which, relevant to the data necessary to assign a patient to a diagnosis related group, are either inconsistent, incomplete, or not sufficiently specific.

(ii) A hospital having 10 percent or less of its discharge data which is incomplete, inconsistent or not sufficiently specific shall have its case mix change calculated on the basis of the patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.3 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights (SIWs) developed by the Department, and diagnosis related groups. The SIWs that shall be used shall be payor-specific.

(iii) A hospital having more than 10 percent of its discharge data which is incomplete, inconsistent or not sufficiently specific shall have its case mix change calculated on the basis of the patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.3 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights, and patient groupings which shall include major diagnostic categories and may include such factors as:

- (a) presence of surgical procedures other than imaging procedures;
- (b) sex; and

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The SIWs that shall be used shall be payor-specific:

(4) In 1986, hospitals shall have their operating rates adjusted for only those payors whose case mix index calculated according to the provisions of paragraph (3) of this subdivision changes by 1 percent or more. Adjustment shall be made according to the provisions of paragraph (5) of this subdivision.

(5) (4) The rates of payment and revenue caps of hospitals eligible for a case mix adjustment shall be adjusted as follows:

(i) [in no case shall the first 1 percent of change in case mix be reflected in an adjustment to hospital rates of payment and revenue caps, except as calculated for rate years 1984 and 1985 pursuant to paragraph (2) of this subdivision;

(ii) for those hospitals receiving an adjustment pursuant to the provisions of paragraph (3) of this subdivision the operating cost per diems paid to hospitals shall be adjusted upward or downward in direct proportion to the percent of change in case mix, as measured according to the provisions of either paragraph (1) or [(3)] (2) of this subdivision, as appropriate, that exceeds [1 percent, except as provided in paragraph (2) of this subdivision] the corridors established in paragraph (3) of this subdivision and in accordance with subparagraph [(ii)] ii of this paragraph; and

[(iii)] ii the commissioner shall not recognize the total upward case mix adjustment provided for in this subdivision if he finds that prior rate year adjustments have previously reimbursed a portion of all of such case mix associated cost increases. Such prior rate year adjustments shall include adjustments pursuant to section 86-1.12 of this Subpart which included an adjustment for case mix and that portion of any rate adjustment made pursuant to paragraphs (1), (3), (4) and/or (7) of section 86-1.17(a) of this Subpart which accounted for a change in case mix.

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**86-1.12° Volume adjustment.** Within six months following the rate period, a volume adjustment to the rate will be made for those hospitals which meet the following criteria and which are entitled pursuant to the following calculations:

- (a) The adjustment will be available for all hospitals except those:
  - (1) which closed during the rate year of the volume adjustment; and
  - (2) with rates calculated based on budget.

(b) The rate will be adjusted according to the following rules:

(1) The change in total certified days will be construed as the net change in total certified days attributable to a change in the facility's average length of stay from the base year to the rate year and a change in the facility's number of discharges from the base year to the rate year.

(2) Any change of less than one percent in total certified days from the base year to the rate year, adjusted for leap years, will result in no rate adjustment.

(3) Any change of less than five percent but greater than or equal to one percent in total certified days from the base year to the rate year, adjusted for leap years, will result in an automatic rate adjustment, from which there shall be no administrative appeal.

(i) In calculating this automatic rate adjustment, it will be recognized that all of a facility's capital costs are fixed. Operating costs shall be considered fixed where there are decreases in volume as measured by discharges and/or average length of stay. Operating costs shall be considered variable where there are increases in volume as measured by discharges and/or average length of stay.

(ii) That portion of the automatic rate adjustment for operating costs attributable to the facility's change in average length of stay from the base year to the rate year shall be made incrementally according to the steps in the following table:

Decrease in Patient Days		Increase In Patient Days	
(% Change)	Fixed Variable Percent	(% Change)	Fixed Variable Percent
0 to 5	80/20	0 to 5	80/20
5+ to 7	75/25	5+ to 7	75/25
7+ to 10	70/30	7+ to 10	70/30
10+	65/35	10+	65/35

(iii) That portion of the automatic rate adjustment for operating costs attributable to the facility's change in discharges from the base year to the rate year shall be made incrementally according to the steps in the following table:

\* Used in the calculation of rates for the period January 1, 1983 through December 31, 1987.

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Decrease in Patient Discharges		Increase in Patient Discharges	
(% Change)	Fixed Variable Percent	(% Change)	Fixed Variable Percent
0 to 6	60/40	0 to 6	60/40
6+	50/50	6+	50/50

(4) A change greater than or equal to five percent in total certified days between the base year and the rate year, adjusted for leap years, will result in a further rate adjustment which will be in accordance with subparagraphs (3)(i)-(iii) of this subdivision.

(i) A facility having a change in total certified days of greater than or equal to five percent may ask the commissioner to review the reasons for the change in volume and to revise the target volume and/or fixed and variable percentage(s). The commissioner shall determine the cause for the change and its relation to the efficient costs of providing patient care services. Based upon this review, the commissioner may adjust the target volume and/or the fixed and variable percentage(s) cited in paragraph (3) of this subdivision upward and/or downward, independent of the facility's request to allow the hospital to be reimbursed for the costs of efficient production of services for the change in volume.

(ii) Facilities having a change in total certified days of greater than or equal to five percent shall have the right to administratively appeal their rate adjustment pursuant to section 86-1.17 of Subpart, within 120 days of receipt of the initial notice of said adjustment.

(c) Similarly, when utilization in the base year or rate year is affected by labor strikes, lockouts, or by the establishment of a certified hospital-based ambulatory surgery service as defined in section 405.2(n) of this Title, a proportionate revision to the target volume will be determined.

(d) All payment adjustments resulting from the application of this provision shall be made within six months following the republication of rate referred to above.

(e) Volume adjustment for 1986 and 1987. Within six month following the rate period, a volume adjustment to the rate will be made in accordance with subdivisions (a) through (d) of this section based upon changes in utilization between 1985 as the base year and 1986 as the rate year, and 1986 as the base year and 1987 as the rate year, with the following exceptions:

(1) The volume adjustment shall take into consideration only changes in total certified days for other than beneficiaries of title XVIII of the Federal Social Security Act.

(2) The commissioner may provide for the volume adjustment in the rate year if the facility submits in writing a request for such an adjustment and the facility decertifies at a minimum the equivalent of the number of beds comprising one nursing unit.

(3) If a hospital has experienced a change of greater than five percent in total certified days between 1981 (base year) and 1985

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(rate year), and did not meet minimum medical/surgical utilization requirements of section 86-1.9 of this Subpart in 1985, and received a rate adjustment in accordance with this section, 86-1.12, for the 1985 rate year, the commissioner shall adjust such hospital's 1987 rate for changes in certified days from 1986 to 1987 and shall, in calculating such hospital's 1987 per diem inpatient rate, include those imputed medical/surgical days necessary to meet the minimum medical/surgical utilization requirements pursuant to section 86-1.9 unless such hospital submits in writing by December 31, 1987 a request to decertify the beds necessary to meet such minimum medical/surgical utilization requirements. In no event shall the volume adjustment computed in accordance with this paragraph result in a per diem rate greater than the hospital's actual rate year inpatient per diem costs.

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Section 86-1.13 Groupings. (a) For the purpose of establishing routine and ancillary cost ceilings (for other than specialty hospitals), ~~peer groups of hospitals shall be developed taking into consideration, but not limited to, the following general criteria:~~

- (1) case mix;
- (2) service mix;
- (3) patient mix;
- (4) size of facility;
- (5) teaching activity; and
- (6) geographic location.

(b) Based on the variables listed in subdivision (a) of this section, the commissioner shall establish a group for each facility in which the facility is at the center of its group--called seed clustering. The size of each group may be variable and shall be determined using acceptable statistical parameters which define the degree of comparability within each group. For the purpose of grouping in accordance with seed clustering, hospitals will be stratified to separate facilities located in the Blue Cross/Blue Shield of Greater New York region from facilities in the rest of the State.

(c) In the event a hospital fails to submit the data required for inclusion in a group which is developed in accordance with subdivision (a) of this section, the commissioner, on the basis of available data, shall develop proxy measures for the required variables, and based on these measures shall construct a peer group. The proxy variables shall not have a financial impact on any facility except that which failed to submit the requisite data.

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Section 86-1.14 Ceilings on payments. (a) Reimbursement rate ceilings will be established as specified in this section for comparable ~~groups of medical facilities (except specialty hospitals)~~ developed in accordance with section 86-1.13 of this Subpart. The ceilings shall be established after the application of a wage equalization factor and a power equalization factor but prior to the addition of a factor to bring costs to projected expenditure levels during the effective period of the reimbursement rate.

(b) Facilities with ancillary costs less than 75 percent or over 125 percent of the peer group weighted average shall have such costs raised or lowered to the specified limits. The peer group weighted ancillary average cost of the respective groups shall then be recomputed with these adjustments. The original ancillary costs of such facilities shall be subject to the ceilings.

(c)(1) In computing the allowable costs for inpatient routine services for hospitals, no amount shall be included that is in excess of 107.5 percent of the weighted average per diem cost, using total expected patient days developed from application of the length of stay standards, of routine inpatient services of all hospitals in the peer group. For the purposes of this calculation, the total expected patient days shall also include imputed days. For the purpose of this computation, routine inpatient services shall not include capital costs, or costs of schools of nursing, ambulance services, interns and residents, supervising physicians and other physicians. In computing the allowable costs for ancillary services for hospitals, no amount shall be included that is in excess of 105 percent of the weighted average per discharge cost of ancillary services (including imputed discharges) of all hospitals in the peer group. For the purpose of this computation, ancillary services shall not include capital costs, costs of schools of nursing, ambulance services, interns and residents, supervising physicians and other physicians. In determining a facility's disallowances, its routine and ancillary ceilings shall subsequently be adjusted to consider differences in a hospital's case mix complexity relative to its peers.

(2) For the purpose of establishing limits on allowable costs for interns and residents, supervising physicians and other individual physicians, no amount shall be included which is in excess of their operational cost per day in the prior year inflated by the price index used for physician services as developed in section 86-1.15 of this Subpart. For the purpose of this computation, other costs excluded from peer group ceiling calculations as set forth in paragraph (1) of this subdivision, shall not be included.

(d) For the purposes of adjusting the allowable costs for inpatient routine services for other than specialty hospitals, a total length of stay standard for each hospital will be developed which shall take into consideration the following variables:

- (1) patient mix characteristics;
- (2) whether the hospital is a teaching or nonteaching institution;

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~~(3) the diagnostic mix of the hospital, including whether the hospital has a certified hospital-based ambulatory surgery service;~~

(4) presence or absence of surgery; and

(5) the geographic region the hospital is located in.

For the purpose of establishing standards a teaching hospital is one which has a special educational index greater than 100, as determined by the commissioner.

(e) For the purpose of establishing limits on allowable costs for a specialty hospital, a weighted average percentage change in operational cost per day from the prior year to the base year will be computed for facilities in that hospital's region. In computing the allowable cost for specialty hospitals no amount shall be included which is in excess of their operational cost per day in the prior year inflated by the aforementioned average percent change. For the purpose of this computation, costs excluded from peer group ceiling calculations, as set forth in subdivision (c) of this section shall not be included. In addition, reimbursement for specialty hospitals shall be limited to the movement in the application of the trend factor established under section 86-1.15 of this Subpart for 1984 and 1985 reimbursement periods. The allowances and pool distributions described in 86-1.11 shall be available to specialty hospitals pursuant to the conditions of that section.

\* \* \*

(h) Limits on ceiling disallowances. (1) The total percentage of regional operational disallowances, excluding the minimum utilization disallowances, will be limited to the percentage of 1982 regional costs disallowed as a result of routine disallowances and one-half the length of stay disallowances, adjusted by a statewide adjustment factor, plus ancillary disallowances and the professional component limitation as set forth in subdivision (c) of this section. This maximum disallowance and the rate year disallowance subject to it will be adjusted to reflect appeals. Any excess disallowance in 1983 will result in proportionate relief to all hospitals subject to the disallowance within the affected region.

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86-1.15<sup>a</sup> Calculation of trend factor. (a) The commissioner shall establish a trend factor for allowable operating cost increases during the effective period of the reimbursement rate. Such factor shall be determined as follows:

(1) The elements of a medical facility's costs shall be weighted based upon data for the following categories:

- (i) salaries;
- (ii) employee health and welfare expense;
- (iii) nonpayroll administrative and general expense;
- (iv) nonpayroll household and maintenance expense;
- (v) nonpayroll dietary expense; and
- (vi) nonpayroll professional care expense.

(2) Each weight shall be adjusted by the appropriate price index for each category noted above, as well as for subcategories. Included among these cost indicators are elements of the United States Department of Labor consumer and wholesale price indices and special indices developed by the State Commissioner of Health for this purpose.

(3) Geographic differentials may be established where appropriate.

(4) The cost indicators used in determining the projection factors shall be compared on a semiannual basis with available data on such indicators, and any other economic indicators as deemed appropriate by the Commissioner of Health. Based upon such review the commissioner may, in his discretion, either certify new rates or adjust subsequent rates for any period or portion thereof when he determines that such new rates or adjusted rates are necessary to avoid substantial inequities arising from the use of previously certified rates.

(5) This subdivision has been superseded by section 2807-a(8) of the Public Health Law. The commissioner shall implement adjustments to the trend factor semiannually; provided, however, that adjustments, except for the final adjustment, in the trend factor, shall not be required unless such adjustment would result in the weighted average of the operating cost component of the rates of charge limits differing by more than one half of one percent from that which was previously determined.

(b) (1) The maximum increase in allowable charges shall be calculated by the use of the trend factors calculated in accordance with the methodology described in subdivision (a) of this section.

(2) The maximum allowable increase in gross inpatient charges shall be the product of allowable 1982 gross inpatient charges, the 1983 trend factor, and the ratio of 1981 inpatient costs to 1980 gross inpatient charges.

<sup>a</sup> Used in the calculation of rates for the period January 1, 1983 through December 31, 1987.

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(3) The provisions of this subdivision shall expire on  
December 31, 1983.

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Section 86-1.16 Adjustments to provisional rates based on errors. Rate appeals pursuant to section 86-1.17(a)(1)-(2) of this Subpart, if not commenced within 120 days of receipt of the commissioner's initial rate computation sheet, may be initiated at time of audit of the base year cost figures upon or prior to receipt of the notice of program reimbursement. Such rate appeals shall be recognized only to the extent that they are based upon mathematical or clerical errors in the cost and/or statistical data as originally submitted by the medical facility, or revisions initiated by a third-party fiscal intermediary or, in the case of a governmental facility, by the sponsor government, or mathematical or clerical errors made by the Department of Health. Such notice of appeal must be presented in writing prior to or at the exit conference for such audits.

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Section 86-1.17 Revisions in certified rates. (a) The State Com  
of Health shall consider only those applications for prospective r  
of certified rates and any established revenue cap in the current y  
are in writing and are based on one or more of the following:

(1) reserved

(2) reserved

(3) reserved

(4) Documented increases in the overall operating  
a medical facility resulting from capital renovation, expansion, re  
or the inclusion of new programs, staff or services approved for th  
facility by the commissioner through the certificate of need (CON)  
The provisions of this paragraph shall be applicable with respect t  
filed with payors, including article 43 corporations and intermedi  
responsible as payors for titles XVIII and XIX Social Security Act  
To receive consideration for reimbursement of such

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costs in the current rate year, a facility shall submit, at time of appeal or as requested by the commissioner, detailed staffing documentation, proposed budgets and financial data, anticipated unit costs and incremental costs for all directly and indirectly affected cost centers, initiated by the approved CON application involving any of the aforesaid activities pursuant to section 710.1 of this Title.

(i) reserved

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(ii) If after the application of the programmatic and cost analyses, the commissioner determines that the budgeted incremental operating costs are more than 7.5 percent of base year reimbursable operating costs for the rate(s) and rate year being appealed, a facility shall be reimbursed as follows:

(a) Net incremental costs, which are based on budgeted data, shall be determined by the commissioner after programmatic and cost analyses. Such analyses shall include, but not be limited to, a facility-wide review of cost centers directly and indirectly affected by the approved CON project. Such analyses shall result in a determination which limits budgeted costs as follows:

(1) Net increases in staffing shall be evaluated in accordance with the department peer group guidelines. For the purpose of establishing peer group staffing guidelines, at least the following general criteria shall be considered:

(i) number of certified beds;

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(ii) allocation statistics appropriate to each cost center or unit of service; and

(iii) number of full-time equivalents (FTE's) per each cost center or unit of service.

Based on the groups established pursuant to the above, the commissioner shall develop staffing guidelines which shall be the average of staffing within a group for each cost center or unit of service. The guidelines developed through this process in conjunction with the programmatic review shall be used to evaluate the appealing facility's requested FTE complement per cost center or unit of service.

(2) Nonsalary reimbursable operating costs shall be limited to the facility's base year unit costs or, if these are not available, to group average unit costs, trended forward to the respective rate year by the trend factor established according to section [86-1.15] 86-1.58 of this Subpart, multiplied by the appropriate budgeted statistics.

(3) Energy costs shall be reimbursed in full if the facility can document that it has:

(i) performed an energy audit pursuant to the guidelines of the State Energy Office in the "Energy Audit Report, EA-1 10-80 (revised as of October 1980), General

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Instructions, Grant Programs for Schools and Hospitals and Buildings Owned by Units of Local Government and Public Care Institutions" and the accompanying Energy Audit Report, which are hereby incorporated by reference. Copies of the Energy Audit General Instructions and Report may be obtained from the New York State Energy Office, Empire State Plaza, Agency Building 2, 20th Floor, Albany, New York 12223. A copy is available for inspection and copying at the Records Access Office of the New York State Department of Health, Erastus Corning 2nd Tower, Empire State Plaza, Albany, New York 12237, and at the New York State Department of State, 162 Washington Avenue, Albany, New York 12231; and

(ii) adhered to Subchapter C, Chapter 2, Subtitle BB of Title 9 NYCRR (New York State Lighting Standards), as adopted by the New York State Energy Office on September 16, 1980, hereby incorporated by reference with respect to any new construction which is the subject of an appeal hereunder.

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(4) If compliance with the above energy standards has not been documented, then energy costs shall be limited to the base year costs trended forward to the respective year by the trend factor established pursuant to section [86-1.15] 86-1.58 of this Subpart, multiplied by the appropriate budgeted statistics.

(b) reserved

(c) reserved

(d) reserved

(e) reserved

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Supersedes Tii 85-34 Effective Date JAN 1 - 1989

(5) reserved

(6) reserved

(7) reserved

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Supersedes Tii: 85-34 Effective Date JAN 1 - 1989

- (8) reserved
- (9) reserved
- (b) reserved

(c) An application by a medical facility for review of a certified rate is to be submitted on forms provided by the department and shall set forth the basis for the appeal and the issues of fact. Documentation shall accompany the application, where appropriate, and the department may request such additional documentation as determined necessary.

(1) The affirmation or revision of the rate upon such staff review shall be final, unless within 30 days of its receipt a hearing is requested, by registered or certified mail, before a rate review officer on forms supplied by the department. The request shall contain a statement of the factual issues to be re-

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Supersedes Tii: 85-34 Effective Date JAN 1 - 1989

solved. The facility may submit memoranda on legal issues which it deems relevant to the appeal.

(2) Where the rate review officer determines that there is no factual issue, the request for a hearing shall be denied and the facility notified of such determination. No administrative appeal shall be available from this determination. The rate review officer, where he determines that there is factual issue, shall issue a notice of hearing establishing the date, time and place of the hearing and setting for the factual issues as determined by such officer. The hearing shall be held in conformity with the provisions of section 12-a of the Public Health Law and the State Administrative Procedure Act.

(3) The recommendation of the rate review officer shall be submitted to the Commissioner of Health for final approval or disapproval and recertification of the rate where appropriate.

(4) The procedure set forth in this subdivision shall apply to all applications for rate reviews which are pending as of April 1, 1978. Rate appeals filed prior to April 1, 1978 will not be required to be resubmitted subsequent to April 1, 1978.

(d) Reserved

(e) In reviewing appeals for revisions to certified rates, the commissioner may refuse to accept or consider an appeal from a medical facility:

(1) providing an unacceptable level of care as determined after review

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- (2) operated by the same management when it is determined by the department that this management is providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council in one of its facilities;
- (3) where it has been determined by the commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law; or
- (4) where a fine or penalty has been imposed on the facility and such fine or penalty has not been paid. In such instances subdivision (d) of this section shall not be effective until the date the appeal is accepted by the commissioner.
- (f) Any medical facility eligible for title XVIII (Medicare) certification providing services to patients insured under title XIX which is not, or ceases to be, a title XVIII provider of care shall have its current reimbursement rate reduced by 10 percent. This rate reduction shall remain in effect until the first day of the month following certification of such a provider by the title XVIII program. Such rate reductions shall be in addition to any revision of rates based on audit exceptions.

(g) reserved

(h) reserved

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(i) reserved

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86-1.18 Rates for services. (a) The State Commissioner of Health shall, in certifying schedules for government payments to hospitals, separately identify all-inclusive prospective rates for inpatient services, emergency services, clinic services and such other services for which a separate rate is deemed appropriate by the commissioner.

(b) Payment for newborns shall be made at one third of the mother's rate.

(c) The State Commissioner of Health shall, in certifying schedules for government payments to hospitals, establish one all-inclusive prospective rate for inpatient hospital care to reflect the services provided by each facility possessing a valid operating certificate. In addition, the commissioner shall identify and certify all-inclusive prospective rates for emergency services, clinic services and for such other services as deemed appropriate.

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Section 86-1.19 Rates for medical facilities without adequate cost experience. (a) This subdivision shall apply where the fiscal and statistical data of the facility are unavailable through no fault of the provider or its agents, and due to circumstances beyond its control, or when there is a new facility without adequate cost experience, or when there is a new service for which there is a discrete rate and which is without adequate cost experience.

(b) The rates certified for such medical facilities or approved services as set forth in subdivision (a) of this section, shall be determined on the basis of generally applicable factors, including but not limited to the following:

- (1) the usual and customary rates, for comparable services, in the geographic area;
- (2) satisfactory cost projections;
- (3) allowable actual expenditures; and
- (4) an anticipated utilization of no less than the average for the geographic area or the minimums established in this Part, whichever is greater.

\* \* \*

(d) All rates of reimbursement certified pursuant to this section shall be subject to audit pursuant to section 86-1.8 of this Subpart. After audit, the facility shall receive a rate based upon actual allowable costs incurred during the rate period, consistent with the provisions of this Subpart.

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Section 86-1.20 Less expensive alternatives. Reimbursement for the cost of providing services may be the lesser of the actual costs incurred or those costs which could be reasonably anticipated if such services had been provided by the operation of joint central services or use of facilities or services which could have served as effective alternatives or substitutes for the whole or any part of such service. In this respect, the chief executive officer of a medical facility will be required to submit to the State Department of Health as an attachment to the uniform financial report, effective with report periods beginning on or after January 1, 1977, an affidavit delineating the medical facility's practices of pursuing joint central services or less expensive alternatives. There must be a letter accompanying the affidavit, reflecting the health systems agency's acknowledgment that they have received such affidavit.

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85-34  
supersedes  
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Section 86-1.21 Allowable costs. (a) To be considered as allowable in determining reimbursement rates, costs must be properly chargeable to necessary patient care. Except as otherwise provided in this Part, or in accordance with specific determination by the commissioner, allowable costs shall be determined by the application of the principles of reimbursement developed for determining payments under the title XVIII (Medicare) program.

(b) Allowable costs may not include costs for services that have not been approved by the commissioner.

(c) Allowable cost shall include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a facility.

(d) Allowable costs may not include amounts in excess of reasonable or maximum title XVIII (Medicare) costs or in excess of customary charges to the general public. This provision shall not apply to services furnished by public providers free of charge or at a nominal fee.

(e) Allowable costs shall not include expenses or portions of expenses reported by individual facilities which are determined by the commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item.

(f) Any general ceilings applied by the commissioner, as to allowable costs in the computation of reimbursement rates, shall be published in a hospital memorandum or other appropriate manner.

(g) [Reserved]

(h) Allowable costs shall not include costs which principally afford diversion, entertainment or amusement to their owners, operators or employees.

(i) Allowable costs shall not include any interest charged or penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty.

(j) Allowable costs shall not include the direct or indirect costs of advertising, public relations and promotion except in those instances where the advertising is specifically related to the operation of the facility and not for the purpose of attracting patients.

(k) Allowable costs shall not include costs of contributions or other payments to political parties, candidates or organizations.

(l) Allowable costs shall include only that portion of the dues paid to any professional association which has been demonstrated, to the satisfaction of the commissioner, to be allocable to expenditures other than for public relations, advertising and political contributions. Any such costs shall also be subject to any cost ceilings that may be promulgated by the commissioner pursuant to subdivision (f) of this section.

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(m) [Reserved]

(n) Allowable costs shall not include any element of cost, as determined by the commissioner, to have been created by the sale of a medical facility.

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Section 86-1.22 Recoveries of expense. Operating costs shall be reduced by the cost of services and activities which are not properly chargeable to patient care. In the event that the State Commissioner of Health determines that it is not practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs of these services and activities. Examples of activities and services covered by this provision include:

- (a) drugs and supplies sold for use outside the medical facility;
- (b) telephone and telegraph services for which a charge is made;
- (c) discount on purchases;
- (d) living quarters rented to employees;
- (e) employee cafeterias;
- (f) meals provided to special nurses or patients' guests;
- (g) operation of parking facilities for community convenience;
- (h) lease of office and other space of concessionaries providing services not related to medical service;
- (i) tuitions and other payments for educational service, room and board and other services not directly related to medical service.

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86-1.23 Depreciation. (a) Reported depreciation based on historical cost is recognized as a proper element of cost. Useful lives shall be the higher of the reported useful life or those useful lives from the Estimated Useful Lives of Depreciable Hospital Assets, 1983 edition, American Hospital Association, consistent with title XVIII provisions. This regulation is effective for depreciable assets purchased on or after January 1, 1978. Copies of this publication are available from the American Hospital Association, 840 North Lake Short Drive, Chicago, IL 60611, and a copy is available for inspection and copying at the offices of the records access officer of the Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.

(b) In the computation of rates effective January 1, 1975 for voluntary facilities, depreciation shall be included on a straight-line method on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight line method or accelerated under a double declining balance or sum-of-the-years' digit method. Depreciation shall be funded unless the Commissioner of Health shall have determined, upon application by the facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. Effective with the fiscal year starting on or after January 1, 1981 in instances where funding is required (that being the transfer of monies to the funded accounts), depreciation on major movable equipment shall be funded in the year revenue is received from the reimbursement of each expense and in the amount included in reimbursement for that year. In instances where funding is required, such fund may be used only for capital expenditures with approval as required for the amortization of capital indebtedness. Funding for plant and fixed equipment shall mean that the transfer of monies to the funded accounts shall occur by the end of the fiscal period in which the depreciation is recorded. Board-designated to/from accounts shall not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts [for six months or more] to be considered as valid funding transactions unless expended for the purposes for which it was funded.

(c) In the computation of rates effective January 1, 1975 for public facilities, depreciation is to be included on a straight-line method on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight-line method or accelerated under a double declining balance or sum-of-the-years' digits method.

(d) In the computation of reimbursement rates for proprietary facilities, depreciation is to be computed on a straight-line basis on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight-line method or accelerated under a double declining balance or sum-of-the-years' digits method.

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(e) Medical facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law shall conform to the requirements of this Subpart. In lieu of depreciation and interest, on the loan financed portion of the facilities, the State Commissioner of Health shall allow level debt service on the mortgage loan, for all loans approved for financing prior to January 1, 1990, together with such required fixed charges, sinking funds and reserves as may be determined by the Commissioner as necessary to assure repayment of mortgage indebtedness. For loans approved for financing on or after January 1, 1990, medical facilities shall receive reimbursement in the form of interest and depreciation in accordance with the remainder of this Subpart.

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(ii) any remaining amount of investment income, after application of paragraph (i), shall be used to reduce capital interest expense reimbursed that year for medical facilities; and

(iii) any remaining amount of investment income after application of paragraph (ii) shall not be considered in the determination of allowable costs.

(d) Interest on current indebtedness shall be treated and reported as an operating, administrative expense.

(e) Interest on capital indebtedness is an allowable cost if the debt generating the interest is approved by the commissioner, incurred for authorized purposes, and the principal of the debt does not exceed either the approval of the commissioner or the cost of the authorized purposes.

Capital indebtedness shall mean all debt obligations of a facility that are:

(1) evidenced by a mortgage note or bond and secured by a mortgage on the land, building or nonmovable equipment; a note payable secured by the nonmovable equipment of a facility; a capital lease;

(2) incurred for the purpose of financing the acquisition, construction or renovation of land, building or nonmovable equipment;

(3) found by the commissioner to be reasonable, necessary and in the public interest with respect to the facility. Interest related to refinancing indebtedness shall be considered an allowable cost only to

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the extent that it is payable with respect to an amount equal to the unpaid principal of the indebtedness then being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of the refinanced indebtedness will be allowable on acceptance demonstration to the Commissioner of Health that such refinancing will result in a debt service savings over the life of the indebtedness; or

(4) incurred for the purpose of advance refunding of debt.

[Losses] Gains and losses resulting from the advanced refunding of debt shall be treated and reported as a deferred charge or asset. This deferred charge or asset is to be amortized on a straight-line basis over the period to the scheduled maturity date of the refunding debt.

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Supersedes TN New Effective Date MAR 11 1992

(f) Where a public finance authority has established a mortgage rate of interest such that sufficient cash flows exist to retire the mortgage prior to the stated maturity, the amount of the mortgage to be forgiven, at the time of such forgiveness, shall be capitalized as a deferred asset and amortized over the remaining mortgage life, as a reduction to the facility's capital expense.

(g) Voluntary facilities shall report mortgage obligations, financed by public finance authorities for their benefit and which they are responsible to repay, as liabilities in the general fund, when such mortgage obligations are incurred.

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Section 86-1.25 Research. (a) All research costs shall be excluded from allowable costs in computing reimbursement rates.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understandings, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.

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Section 86-1.26 Educational activities. The costs of educational activities less tuition and supporting grants shall be included in the calculation of the basic rate provided such activities are directly related to patient care services.

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Section 86-1.27 Compensation of operators and relatives of operators. (a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable cost. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a nonrelated employee, as determined by the State Commissioner of Health. Compensation shall not be included in the rate computation for any services which the operator or relative of the operator is not authorized to perform under New York State law and regulation.

(b) Any amount reported as compensation for services rendered by an operator or relative of an operator shall not be allowed in excess of the maximum allowance for full time services in carrying out his primary function.

(c) For purposes of subdivision (a) of this section, in determining a reasonable level of compensation for operators or relatives of operators, the commissioner may consider the quality of care provided to patients by the facility during the year in question.

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Section 86-1.28 [Costs of related] Related organizations. (a) A related organization shall be defined as any entity which the medical facility is in control of or is controlled by, either directly or indirectly, or an organization or institution whose actions or policies the facility has the power, directly or indirectly, to significantly influence or direct, or a special purpose organization, or where an association of material interest exists in an entity which supplies goods and/or services to the medical facility, or any entity which is controlled directly or indirectly by the immediate family of the operator. Immediate family shall include each parent, child, spouse, brother, sister, first cousin, aunt and uncle, whether such relationship arises by reason of birth, marriage or adoption. A special purpose organization shall be defined as an organization which is established to conduct certain of the facility's patient-care-related or non-patient-care-related activities. The special purpose organization shall be considered to be related if:

(1) the facility controls the special purpose organization through contracts or other legal documents that allow direct authority over the organization's activities, management and policies; or

(2) the facility is, for all practical purposes, the sole beneficiary of the special organization's activities. The facility shall be considered the special purpose organization's sole beneficiary if one or more of the three following circumstances exist:

(i) a special purpose organization has solicited funds in the name of and with the expressed or implied approval of the facility, and substantially all the funds solicited by the organization were intended by

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the contributor or were otherwise required to be transferred to the facility or used as its discretion or direction;

(ii) the facility has transferred some of its resources to a special purpose organization, substantially all of whose resources are held for the benefit of the facility; or

(iii) the facility has assigned certain of its functions (such as the operation of a dormitory) to a special purpose organization that is operating primarily for the benefit of the facility.

(b) The costs of goods and/or services furnished to a medical facility by a related organization are included in the computation of the basic rate at the lower of the cost to the related organization or the market price of comparable goods and/or services available in the medical facility's region within the course of normal business operations.

(c) If the medical facility has incurred any costs in connection with a related organization, the final payment rate shall include the costs of such goods and/or services.

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Section 86-1.29 Return on investment. (a) In computing the allowable costs of a proprietary medical facility, there shall be included an allowance of a reasonable return on the average equity capital representing the investment by an owner used for the provision of patient care. The percentage to be used in computing the allowance shall be a rate determined annually by the commissioner as reasonably related to the then current money market.

(b) Equity capital is the net worth of the provider adjusted for those assets and liabilities which are not related to the provision of patient care. Equity capital consists of the provider's investment in plant, property and equipment, net of depreciation, and working capital for necessary and proper operation for patient care activities.

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Section 86-1.30 Capital cost reimbursement. The capital cost of a facility for purposes of determining and certifying the capital cost component of a rate shall be determined and computed in accordance with the provisions of sections 86-1.23, 86-1.24, 86-1.29, 86-1.59 of this Subpart and be certified and audited as actually having been expended; provided, however, that:

(a) with respect to a facility for which a rate has been determined and certified by the Commissioner of Health prior to March 10, 1975, the Commissioner of Health may continue such method and computation of such rate or make such modifications and changes to lower such rate as in his judgement are necessary and proper and in the public interest; and

(b) with respect to a facility which has been established by the Public Health Council, and for which a rate has not been determined and certified by the Commissioner of Health prior to the effective date of this section, and a legally binding arms length lease was the basis for the establishment approval granted by the Public Health Council, the Commissioner of Health may determine and certify a rate on the basis of such lease. A lease with a related organization described in subdivision (a) of section 86-1.28 of this Subpart shall be deemed to be a non-arms length lease.

(c)(1) The provisions of this section shall not apply to any facility which, as of the effective date of this Subpart, is located in and operated from leased space pursuant to a lease:

(i) which was entered into and approved for reimbursement prior to March 10, 1975;

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(ii) which the commissioner finds to be bona fide, valid and noncancelable;

(iii) the terms of which the commissioner finds to be fair and reasonable; and

(iv) the payments, or portion thereof made pursuant to which, are found by the commissioner to be the proper basis for reimbursement of capital cost paid to such facility pursuant to article 28 of the Public Health Law prior to March 10, 1975.

(2) The capital cost component of any facility within the provisions of paragraph (1) of this subdivision shall consist of a payment factor sufficient to reimburse the facility for the total payments required under the base thereof to the extent approved by the commissioner pursuant to paragraph (1) of this subdivision.

(d) In the computation of rates for voluntary medical facilities which are rented from proprietary interests, capital reimbursement shall be computed as if the facility were operated under proprietary sponsorship, except where the realty was previously owned by the voluntary medical facility, or where the proprietary interest has representation on the board of directors of the voluntary medical facility.

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(f) Any capital expenditures associated with non-arms length leases shall be approved and certified to, if required, under the hospital certificate of need process. In the computation of reimbursement for non-arms length leases, the capital cost shall be included in allowable costs only to the extent that it does not exceed the amount which the facility would have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. Accelerated depreciation on these assets may not be included in allowable costs under any circumstances.

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Section 86-1.31 Termination of service. The Division of Health Care Financing in the Department of Health shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notification shall include a statement indicating the date of the deletion or the withholding of such service and the cost impact on the medical facility of such action. Any overpayments by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 86-1.8(f) of this Subpart.

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Section 86-1.32 Sales, leases and realty transactions. (a) If a medical facility is sold or leased or is the subject of any other realty transaction before a rate for the facility has been determined and certified by the Commissioner of Health, the capital cost component of such rate shall be determined in accordance with the provisions of sections 86-1.23, 86-1.24, 86-1.29 and 86-1.30 of this Subpart.

(b) If a medical facility is sold or leased or is the subject of any other realty transaction after a rate for the facility has been determined and certified by the commissioner, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realty transaction had not occurred. This subdivision shall not be construed as limiting the powers and rights of the commissioner to change rate computations generally under section 86-1.30 of this Subpart, or specifically when based upon previous error, deceit or any other misrepresentation or misstatement that has led the commissioner to determine and certify a rate which he would otherwise not have determined or certified. Further, this subdivision shall not be construed as limiting the powers and rights of the commissioner to reduce rates when one or more of the original property right aspects related to such a facility is terminated.

(c) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment prior to October 23, 1992, the incurred rental specified in the agreement is includable in allowable costs<sup>1</sup> if the following conditions are met:

<sup>1</sup> Included in rates of payment effective on and after October 23, 1993.

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[(i)] (1) the rental charges are reasonable based on consideration of rental charges of comparable equipment and market conditions in the area; the type, expected life, condition and value of the equipment rented and other provisions of the rental agreements;

[(ii)] (2) adequate alternate equipment which would serve the purpose are not or were not available at lower cost; and

[(iii)] (3) the leasing was based on economic and technical considerations.

[(iv)] (4) If all of these conditions are not met, the allowable rental cost shall not exceed the amount which the provider would have included in reimbursable costs had he retained legal title to the equipment, such as interest, taxes, depreciation, insurance and maintenance costs.

[(v)] (5) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving land, the incurred rental for the cost of land is not includable in allowable costs.

(d) An arms length lease purchase agreement with a nonrelated lessor involving plant facilities or equipment entered into on or after October 23, 1992 which meets any one of the four following conditions, establishes the lease as a virtual purchase.

(1) The lease transfers title of the facilities or equipment to the lessee during the lease term.

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(2) The lease contains a bargain purchase option.

(3) The lease term is at least 75 percent of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment.

(4) The present value of the minimum lease payments (payments to be made during the lease term including bargain purchase option, guaranteed residual value and penalties for failure to renew) equals at least 90 percent of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. Present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case the interest rate implicit in the lease is used.

(e) If a lease is established as a virtual purchase under subdivision (d) of this section, the rental charge is includable in capital-related costs<sup>2</sup> to the extent that it does not exceed the amount that the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership). The cost of ownership shall be limited to depreciation and interest. Further, the amounts to be included in capital-related costs are determined as follows:

(1) The difference between the amount of rent paid and the amount of rent allowed as capital-related costs is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.

<sup>2</sup> Included in rates of payment effective on and after October 23, 1994..

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(2) If an asset is returned to the owner instead of being purchased, the deferred charge may be included in capital-related costs in the year the asset is returned.

(3) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental an amount not in excess of the cost of ownership.

(4) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to a fair rental value.

(5) If the lessee becomes the owner of the leased asset (either by operation of the lease or by other means), the amount considered as depreciation for the purpose of having computed the limitation on rental charges under subdivision (e) of this section, must be used in calculating the limitation on adjustments for the purpose of determining any gain or loss upon disposal of an asset.

(6) In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs had the provider legal title to the asset.

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(f) If a facility enters into a sale and leaseback agreement involving plant facilities or equipment on or after October 23, 1992, the amounts to be included in capital-related costs<sup>3</sup> both on an annual basis and over the useful life of the asset shall not exceed the costs of ownership which shall be limited to depreciation and interest, and shall be determined as follows:

(1) If the annual rental or lease costs in the early years of the lease are less than the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are more than the annual costs of ownership, in the years that the annual rental or lease costs are more than the annual costs of ownership, the facility may include in capital-related costs annually the actual amount of rental or lease costs, except that in any given year, the amount included in capital related costs is limited to an amount which would not cause the aggregate rental or lease costs included up to that year in capital-related costs to exceed the costs of ownership that would have been included in capital-related costs up to that year if the provider had retained legal title to the asset.

(2) If the annual rental or lease costs in the early years of the lease exceed the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are less than the annual costs of ownership, the facility may carry forward amounts of rental or lease costs that were not included in capital-related costs in the early years of the lease due to the costs of ownership limitation, and include these amounts in capital-related costs in the years of the lease when the annual rental or lease costs are less than the annual costs of ownership, provided, however, in any given year the amount of actual annual rental or lease costs plus the amount carried forward to that year

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<sup>3</sup> Included in rates of payment effective on and after October 23, 1993.

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may not exceed the amount of the costs of ownership for that year.

(3) In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs if the provider had retained legal title to the asset.

(4) If a facility enters into a sale and leaseback agreement involving land, the incurred rental for the cost of land is not includable in allowable costs.

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Section 86-1.33 Hospital Closure/Conversion Incentive Programs.

(a) Hospital Closure Incentive Program. To reduce excess beds by encouraging the closure of hospitals, the Commissioner of Health may consider proposals by hospitals which mutually agree that one or more of the hospitals in the group shall close. The plan must be approved by the appropriate health systems agency prior to submission to the Commissioner of Health. The variable costs associated with the closed facility or facilities (which include personnel costs) shall become part of the operating expenses of the remaining facilities in the group. The Commissioner of Health may consider a reasonable incentive structure for increased costs of the remaining facilities if coupled with a strict attrition program that would, within a reasonable period of time, assure a return to an appropriate level of staffing.

(b) Hospital Conversion Incentive Program. (1) To encourage hospitals to reduce excess acute care beds by substantially reducing the certified capacity or by converting a substantial number of such beds to a level of care for which the commissioner has determined a need exists, the commissioner may consider proposals by one or more hospitals which provide for the substantial reduction of acute care beds. Each facility undergoing conversion of beds must submit an individual proposal. The proposal must be reviewed by the appropriate health systems agency prior to submission to the commissioner. The variable costs associated with any layoffs at the converting facility may become part of the operating expenses of the converting facility or the other facilities which are the subject of the proposal. The commissioner may consider a reasonable incentive structure for increased costs of the converting facility or the other facilities if coupled with a strict attrition program that would, within a reasonable period of time, assure a return to an appropriate level of staffing.

(2) Paragraph (1) of this subdivision shall not apply in the case of a conversion caused by a determination under section 2806(6) of the Public Health Law, or where the commissioner finds that a conversion is entered into primarily to avoid the imposition of a utilization penalty.

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Section 86-1.34 Pilot reimbursement projects. (a) The Commissioner of Health may waive the requirements of this Subpart to effect the development of additional knowledge and experience in different types of reimbursement mechanisms, contingent upon the approval of the United States Department of Health, Education and Welfare, and subject to the provisions of section 222(a) of the Social Security Act.

(b) Individual hospitals or groups of hospitals shall enter into such ventures with the understanding that the reimbursement received over the life of this pilot project shall be as defined in the experiment.

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Section 86-1.35 [Reserved]

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86-1.37 Fund administration. (a) The commissioner or his designee shall create and administer the following pools of funds in each region defined in this section: a. financially distressed hospital pool which will be funded by the allowances provided in section 86-1.11(g)(8) of the Subpart;

These pools shall be established for each of the following regions: Long Island (Nassau and Suffolk Counties); New York City (Richmond, Manhattan, Bronx, Queens and Kings Counties); Northern Metropolitan (Delaware, Columbia, Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland and Westchester Counties); Northeastern Blue Cross Region; Utica/Watertown Blue Cross Region; Syracuse Blue Cross Region; Rochester Blue Cross Region; Western Blue Cross Region. Hospitals not participating as of December 31, 1985 in the regional bad debt and charity care pools established pursuant to section 86-1.11 of this Subpart and no longer exempt from the provisions of section 2807-a of the Public Health Law shall be assigned to a region for purposes of calculating the bad debt charity care add-on percentage and making distributions from such pool pursuant to subdivision (p) of section 86-1.11 of this Subpart. Assignment to a region shall be based upon but not limited to the following factors:

- (1) Numbers and types of hospitals within the region and
  - (2) Geographical proximity of the hospital requiring such assignment to a particular region.
- (b) Monthly, each of the major third-party payors (Medicare, Medicaid and article 9C and article 44) will issue separate checks based upon the pool allowances to the pool administrator for each region, based on inpatient hospital claims with a service date on or after January 1, 1983 which were paid for the preceding month: one for the financially distressed hospital pool, and one for the bad debt/charity care pool.

(c) reserved

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category. For 1984 and 1985 the proxy for the "all other payor" category shall be similarly computed using the facility's 1983 and 1984 RCCAC logs, respectively. The facility shall pay to the pool administrator the regional allowances based upon these proxies on a monthly basis, by issuing three checks, one for each pool. Payments for January, February and March of 1983 must be submitted to the pool administrator on or before July 31, 1983. Payments for the months thereafter shall be submitted on or before the 20th day of the fourth month following the calendar month to which the payment applies. The January and February payments to be made to the pool administrator on or before May 20th and June 20th of each year shall be based upon the previous year's proxy. The methodology used to determine the proxy for the 1983, 1984 and 1985 payments received for the "all other payor" category shall not thereafter be adjusted to actual using cash receipts. However, on or about July 1, of each year when the previous year's RCCAC data becomes available, facilities shall recalculate their annual liability for pool contributions for the previous year using this data. This recalculated amount shall also represent a new estimated liability for the current year. Facilities shall compare the newly calculated annual liability for the previous year to

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(d) Concurrent with the submission of pool contribution checks, hospitals shall submit to the pool administrator, information for the "all other payor" category of the facility's RCCAC logs regarding patient days, gross charges, nonpatient care gross charges, such as telephone, television and personal care items, inpatient bad debt and charity care at gross charges, and payments received from billings to Workers' Compensation, No-Fault, and other per diem payors not included in the "all other payor" category, together with such other information as shall be deemed necessary by the commissioner or his designee, to verify the amounts due the pools.

(e) If any hospital shall fail to timely file reports or submit checks in accordance with subdivision (d) of this section, then the distribution of any funds to such hospital

will be withheld until such time as the reports and checks are appropriately submitted by such hospital. In addition, in the event that a hospital will have 30 days from the date of receipt of notification to provide the required reports and checks. Failure to file the reports and checks within this 30-day time period will result in the withholding of 10 percent of that hospital's payments from all major third-party payors until such time as the required reports and checks are received by the pool administrator.

(f) The commissioner or his designee shall receive and invest funds for the aforementioned pools and distribute such funds according to subdivision

(g) of sections 86-1.11 and 86-1.36 of this Subpart. Where the distribution of funds is not dependent on the processing of an application for the funds, the administrator of the pool will distribute any available funds to hospitals by the tenth business day of the month following the month in which such funds were received from the major third-party payors will be made on or before March 14, 1983.

(g) During 1983 in the initial funding process of the pools, the immediate demand for funds from a particular pool may exceed the available funds in such pool. Also, because of a lag in distribution from some pools associated with the application process, some pools may have cash available beyond immediate distribution needs. In order to meet distribution needs as they arise, the commissioner or his designee, may, in 1983, allow borrowing from one pool to another within a region. In no event, however, will such borrowing be allowed

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by one pool from other pools in an amount in excess of projected amounts to be paid for the year by the major third-party payors to the borrowing pool, and in no event will borrowing be permitted if it will impair the ability of the lending pool to meet its distribution needs. All amounts borrowed shall be fully repaid during the first half of 1984.

(h) The major third-party payors shall provide the commissioner or his designee, at the time of check submission, with reports showing the paid claims by region, including, but not limited to the name of each hospital, patient days paid, and the computation by region and by pool of the amounts for which payments to the pools are made.

(i) The commissioner or his designee shall retain amounts in each regional pool, as are projected to be necessary to cover any payments due to third-party payors because of retroactive rate adjustments.

(j) The commissioner is authorized to make contingent distributions from the financially distressed hospital pool upon filing of this regulation, to hospitals participating in the transitional reimbursement program as of December 31, 1982 and to such other hospitals as are found by the commissioner to be in serious financial jeopardy, in amounts necessary to stabilize and maintain operations, taking into account available pool funds. Distributions shall be contingent upon subsequent determinations by the commissioner of hospital participation in the financially distressed hospital pool pursuant to standards to be adopted by the State Hospital Review and Planning Council. After these determinations by the commissioner, any contingent amounts to which such hospitals are found by the commissioner to be unentitled shall be repaid by the hospitals to the pool.

(k) Fund administration in 1986 and 1987 regional pools. The commissioner or his designee shall establish and administer the pools created by the provisions of subdivision (p) and (q) of section 86-1.11 of this Subpart according to the criteria contained in this section applicable to the period January 1, 1985 through December 31, 1985, with the following exceptions for regional pools:

(1) Article 43 corporations and Medicaid shall each issue separate monthly checks to the regional bad debt and charity care pools and to the regional financially distressed facility pools.

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(3) Concurrent with the submission of pool contribution checks, hospitals shall submit to the pool administrator information from the "all other payor" category of the facility's RCCAC logs regarding patient days, gross charges, nonpatient care gross charges, such as telephone, televisions and personal care items, inpatient bad debt and charity care at gross charges, and payments received from billings to Workers' Compensation, No-Fault, article 44 corporations, and other per diem payors not included in the "all other payor" category, together with such other information as shall be deemed necessary by the commissioner or his designee, to verify the amounts due the pools.

(4) If any hospital shall fail to timely file reports or submit checks in accordance with paragraph (3) of this subdivision, the distribution of any funds to such hospital in accordance with the distribution schedule in subdivisions (p) and (q) of section 86-1.11 of this Subpart shall be withheld until such time as the reports and checks are submitted by such hospital. In addition, in the event that a hospital fails to timely submit the required reports and checks, the hospital will have 30 days from the date of receipt of notification to provide the required reports and checks. Failure to file the reports and checks within this 30-day time period will result in the withholding of 10 percent of that hospital's payments from both major third-party payors until such time as the required reports and checks are received by the pool administrator.

(5) The commissioner or his designee shall receive and invest funds for the aforementioned pools and distribute such funds according to subdivisions (p) and (q) of section 86-1.11 and section 86-1.36 of this Subpart. Where the distribution of funds is not dependent on the processing of an application for the funds, the administrator of the pool will distribute any available funds to hospitals by the tenth business day of the month following the month in which such funds were received from both major third-party payors.

(6) Article 43 corporations and the New York State Department of Social Services shall provide the commissioner or his designee, at the time of check submission, with reports showing the paid claims by region, including but not limited to the name of each hospital, patient days paid, and the computation by region and by pool of the amounts for which payments to the pools are made.

(7) The commissioner or his designee shall retain amounts in each regional pool as are projected to be necessary to cover any payments due to third-party payors because of retroactive rate adjustments.

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Section 86-1.38 Alternative reimbursement method for mergers or consolidations. ~~As used in this section, the term merger shall mean the combining of two or more medical facilities, licensed under article 28 of the Public Health law, where such combination is consistent with the public need, would create a new, more economical entity, reduce the costs of operation, result in the reduction of beds and/or improve service delivery. The provisions of this section shall apply only if facilities seek an alternative reimbursement mechanism to complete the merger.~~ Otherwise, reimbursement for merged facilities will be consistent with all other provisions of this Subpart.

(a) Application for merger. A merger shall meet all of the following qualifying criteria and conditions:

(1) There is a demonstrated public need for the existing hospital service in whole or in part at the current site(s) of the applicant. The determination of public need shall be made pursuant to section 2802 of the Public Health Law and in accordance with Part 709 of this Title.

(2) The application must include a demonstration of overall financial savings that can be obtained within three years from the date of inception. This projection of savings should demonstrate reduction of overall costs for the separate entities, and reduction of gross reimbursement based on costs from third-party payors due primarily to reduction in beds or services.

(3) The medical facilities must demonstrate that adequate health care services are and will be provided; that conformity with the State Hospital Code is, and will be, maintained, and an approved plan of correction for any operational and structural deficiencies in accordance with State Hospital Code has been filed.

(b) In order to meet the requirements of paragraph (a)(2) of this section, the facility(s) must submit to the commissioner a plan of merger. This plan should include, but not be limited to:

(1) a description and composition of the proposed governing structure of the facilities submitting the applications;

(2) the development of a market analysis of the population being served;

(3) development of a functional consolidation of services, outlining:

(i) changes in the size and scope of the medical staff organization;

(ii) clinic and outpatient activities;

(iii) the integration of such areas as administration, operation of plant, laboratory, X-ray, therapies, for example;

(iv) redeployment of existing employees and future labor practices; and

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(v) such other information as the commissioner may require

(4) financial plan which provides for:

(i) expected changes in revenues and expenditures due to the actions to be taken by the facilities. This shall be presented in the form of a projected budget for the merged entity and shall include complete budgeted uniform statistical and financial reports; and

(ii) projected changes in salaries, fringe and union benefits;

(5) a capital plan which outlines expected capital outlays necessary to effectuate the planned merger; and

(6) changes in the quality and volume of health services to be provided as a result of the planned merger.

(c) Operating and capital costs reimbursement. Reimbursement under the provisions of this section for mergers meeting the requirements of subdivision (a) of this section shall be determined as follows and shall be for a period not to exceed three years from the date of approval of formal corporate merger of the involved facilities. Following a review of the budgeted statistical and financial data submitted by the facilities, the commissioner shall develop a new group for the merged institution, excluding the projected costs and statistics of the merged institution. All applicable ceilings shall be calculated as required by this Subpart.

(1) Mergers with ceiling penalties. In the event that the merged institution incurs ceiling penalties, the commissioner may waive these penalties for the first full year of operation under the merger. In the second year of operation, facility rates will be the initial approved base year budgeted costs and statistics reduced by an amount that is no less than one third of the amount waived in the first year, increased by the trend factor into the current rate period. In the third year of operation, facility rates will be the initial approved base year budgeted costs and statistics reduced by an amount that is no less than two thirds of the amount waived in the first year, increased by the trend factor into the current rate period.

(2) Mergers without ceiling penalties. In the event that the merged institution incurs no ceiling penalties, rates during the first year of operation will be determined by taking the approved budgeted costs and statistics increased by the appropriate trend factor into the current rate period. In the second year of operation, facility rates will be the initial approved budgeted costs and statistics increased by the appropriate trend factor into the current rate period less two percent. In the third year of operation, facility rates will be the initial approved base year budgeted costs and statistics increased by the appropriate trend factor into the current rate period less four percent.

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(3) Facilities reimbursed under this section will not be eligible for ~~waiver of ceiling penalties in the fourth year of operation as a merged facility.~~ In the fourth year, the facility's reimbursement rate will be based on budgeted costs for the immediately preceding year subject to the standard Part 86 methodology applicable in the fourth year. In all years subsequent to the fourth year, actual base year costs of the facility will be subjected to the standard Part 86 methodology applicable at the time.

(d) Capital Reimbursement. Capital costs associated with a closure of a facility as part of an approved plan under this section will be reimbursable to the new, merged entity subject to appropriate Federal waiver.

(e) Upon application to the commissioner, a volume adjustment as specified in section 86-1.12 of this Subpart may be implemented.

(f) Where a facility(s) covered under this Subpart demonstrates to the commissioner, subsequent to its initial participation in this Subpart, that a deviation from the original approved plan and budget will provide a more cost effective result, a new plan and budget that has been approved by the commissioner will be accepted and utilized in formulation of revised reimbursement rates for the remaining time of participation in this Subpart.

(g) Annual report. Each year a facility(s) covered under this Subpart must demonstrate to the commissioner the cost savings arising from the improved efficiencies and more effective delivery of care due to the merger, consolidation or closure of the facilities participating in the plan. This report should reflect the objectives outlined in the approved plan and be issued by the governing authority of the facilities participating.

(h) Termination of facility(s) participation. Reimbursement under this section shall terminate if:

(1) the facility deviates from its plan of merger without written approval of the commissioner;

(2) the facility fails to continue to meet the criteria delineated in this section; or

(3) three years have passed from the date of certification of the rate established pursuant to this section.

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86-1.39 (88-6)  
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86-1.39 [Workers' compensation and not fault reimbursement rates.] Reserved

TN 88-6 Approval Date AUG 1 1981

Supersedes TN 85-34 Effective Date JAN 01 1980

Section 86-1.40 Alternative reimbursement method for medical facilities with extended phase-in periods. The current reimbursement system may not enable new or substantially changed facilities which require an extended start-up period to proceed in a financially viable manner and, therefore, the following alternative reimbursement method is established to insure that needed and qualifying medical facilities can develop.

(a) Facilities which apply for alternative reimbursement under this section must demonstrate that the following qualifying criteria have been met:

(1) The commissioner is satisfied that adequate health care services are and will be provided by the facility.

(2) There has been a finding by the commissioner that the projected expansion and phase-in of the medical facility is appropriate and in the public interest.

(3) Pursuant to a plan of construction or expansion, approved by the commissioner, the facility will either be opening as a new facility or opening additional beds, commencing additional services, or projecting staffing increases.

(4) The facility can demonstrate to the satisfaction of the commissioner that its staffing and operational costs will, by the end of its approved transition period, be within acceptable staffing guidelines and capable of operating under the standard reimbursement methodology.

(5) The facility must demonstrate that it meets the criteria of a new facility or the criteria set forth in paragraph (4) of section 86-1.17 of this Subpart. A new facility is defined as one that has had no previous cost experience and no previous operating certificate.

(6) There are such other related indications of substantial changes as the commissioner may specify.

(b) Facilities which apply for alternative reimbursement under this section will be required to submit, subject to the approval of the commissioner, the following information at least 60 days prior to the start of the alternative reimbursement period:

(1) a market analysis of the population to be served;

(2) an organization description of the hospital, including a description of the medical staff organization and composition of the governing body;

(3) a detailed plan of the phase-in of routine and ancillary services, beds, staffing levels and expected utilization by major program area during the phase-in period in a manner prescribed by the commissioner;

(4) a detailed transitional financial plan which reflects anticipated revenues, including annual tax levy support and expenditures during the phase-in period, including a facility

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budget which reflects planned services expansion as described in paragraph (b)(3) of this section. If requested by the commissioner, the facility shall provide a line item budget with respect to staffing and personnel, and such detail as prescribed by the commissioner for other than personal service items, including capital.

(c) A facility which meets the criteria and informational requirements in subdivisions (a) and (b) of this section, and has received the commissioner's approval of its detailed transitional financial plan, shall have the operating and capital components of its rate established as follows:

(1) A reimbursement rate established under this section shall only be for a time period as approved in the facility's submitted plan, but no greater than five years.

(2) The capital cost component of the rate for each year of the plan will be based on approved annual budgeted cost, divided by the approved targeted patient volume for the rate year and retrospectively adjusted to actual certified cost.

(3) The operating component of the rate will be determined based on an approved budget subject to the following limitations and adjustments:

(i) Changes in personal service and nonpersonal service costs from the base period to the rate period shall be limited to the same factors for inflation which affect the hospital industry, except that costs associated with the phase-in of beds, programs and services which were not existent in a previous period will be allowed, subject to the review and approval of their incremental costs.

(ii) For each year in transition, a peer group will be simulated for the facility. The simulation will be based on the facility's approved budget and phase-in statistics for the facility. The operating component of the reimbursement rate will be subjected to a maximum of the peer group ceiling increased by no greater than five percent times the remaining years of the transition period.

(iii) If the facility's volume is below the approved target volume, no adjustment shall be made.

(iv) If the facility's volume is above the approved targeted volume by five percent, the facility will be submitted to a volume adjustment to adjust their rate over the approved target for incremental costs.

(v) The hospital will be expected to meet the length of stay standards specified in section 86-1.17 of this Subpart.

(vi) The rates established under this section shall be prospective and be subject to adjustment and audit. A length of stay penalty, utilization penalty and volume adjustment

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may be implemented in the year succeeding the rate period in which the respective requirements are not met.

(d) Reimbursement under this section shall terminate if:

(1) the facility significantly deviates from its approved plan without the written approval of the commissioner;

(2) the facility fails to continue to meet the criteria delineated in this section;

(3) the facility requests to withdraw from this program with the understanding that participation in subsequent rate years is prohibited.

(e) The effective date of the reimbursement rate established pursuant to this section shall be the day on which Federal approval is effective.

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86-1.41 (88-6)  
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86-1.41 [Hospital-based ambulatory surgery rates.] Reserved

TN 88-6 Approval Date AUG 1 1991  
Supersedes TN 85-34 Effective Date JAN 01 1988

Section 86-1.42 Hospital-based Physician Reimbursement Program.  
(a) Definitions. As used in this section:

(1) Physician shall mean hospital-based supervisory and other salaried physicians, excluding interns and residents.

(2) Fringe benefits shall mean fringe benefits required by law, plus health, welfare, retirement, and educational benefits given in lieu of direct compensation.

(3) Total physician compensation shall mean the prospectively set base year compensation for physicians responsible for a service or department plus a fringe benefit allowance not to exceed 25 percent of the base year compensation, less any portion of that compensation which is for other than that service or department.

(4) Total employee staff compensation shall mean the prospectively set base year compensation for nonphysician employees assigned to a service or department, plus a fringe benefits allowance, less any portion of that compensation which is for other than that service or department.

(b) Notwithstanding any other provision of this Subpart, allowable reimbursable costs for physicians responsible for the inpatient diagnostic and therapeutic services or departments of radiology, radiation therapy, ultrasonography, laboratory medicine and pathology, nuclear medicine, electrocardiography and hospital cardiology services, exclusive of cardiac catheterization, shall be 104 percent of total physician and employee staff compensation for each of these services. Allowable reimbursable costs for physicians responsible for clinical laboratory services shall be 103 percent of total physician and employee staff compensation for such services. Reimbursement paid pursuant to this subdivision in excess of actual salaries, fringe benefits, and incentive payments, if any, shall be called professional development funds. These funds shall be distributed by the hospital among the clinical laboratory service and the aforementioned inpatient diagnostic and therapeutic services and departments. These funds shall be considered departmental funds and may be used to improve the clinical care of patients receiving services from the department, to enhance or supplement the department's educational program, and for purchases of hospital patient care equipment. These funds shall be committed annually.

(c) Notwithstanding any other provision of this Subpart, hospitals shall be reimbursed for the cost of a single adjustment to total physician compensation for physicians who are responsible for the inpatient diagnostic and therapeutic services or departments of radiology, radiation therapy, ultrasonography, laboratory medicine including all clinical laboratories and pathology, nuclear medicine, electrocardiography and hospital cardiology services exclusive of cardiac catheterization, provided that the overall compensation for such physicians in aggregate does not exceed the 80th percentile as reported in the American Association of Medical Colleges faculty compensation survey for the base year. This adjustment shall be in an amount sufficient to provide funds for overall compensation of such physicians in the aggregate equivalent to the 80th percentile as reported in the survey. The cost of such adjustment in excess of the

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limitation on allowable costs for such services as set forth in section 86-1.14(c) of this Subpart shall be excluded from the calculation of base period costs and shall be reimbursed.

(d) The provisions of this section shall apply only to those hospitals:

(1) which apply to the commissioner for participation in this program within six months of the effective date of this section;

(2) which have a written agreement with their physicians which specifies physician responsibility with regard to scope of service and education of all physicians on the prudent use of diagnostic services and which specifies productivity and utilization standards for all departments to reduce unit costs of services;

(3) which document a fixed prospective physician compensation arrangement set in advance of the rate year, which may include an incentive plan provided such plan does not exceed 15 percent of the aggregate prospective base compensation and provided such plan has been approved by the commissioner upon a showing by the hospital that incentive plan costs will be offset by equivalent productivity gains and cost savings; and

(4) which, following the first year of participation in the program, document annually an appreciable reduction in unit costs of services as a result of participation in the program.

(e) This section shall be contingent upon Federal financial participation.

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86-1.43 (88-6)  
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86-1.43 (Medicare adjustment) Reserved

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86-1.44 (88-6)  
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86-1.44 [Computation of rates of payment for licensed freestanding  
ambulatory surgery centers.] Reserved

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Section 86-1.45 Federal financial participation. The rates of payment made for inpatient hospital services rendered to title XIX recipients established in accordance with the methodology contained in this Subpart shall ~~be contingent upon Federal financial participation (FFP) and approval.~~

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86-1.46 (88-6)  
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86-1.46 Reserved

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86-1.47 (88-6)  
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86-1.47 Reserved

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86-1.48 (88-6)  
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86-1.48 Reserved

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**Hospital Inpatient Reimbursement - Effective December 1, 2009**

**Definitions.** As used in this Section, the following definitions shall apply:

1. Diagnosis related groups (DRGs) shall mean the 3M Corporation All-Patient-Refined (APR) classification system, which utilizes diagnostic related groups with assigned weights that incorporate differing levels of severity of a patient's condition and the associated risk of mortality, and reflects such factors as the patient's medical diagnosis, severity level, sex, age, and procedures performed.
  - a. For the period December 1, 2009 through December 31, 2010, Version 26.1 of the APR classification system will be used.
2. DRG case-based payment per discharge shall mean the payment to be received by a hospital for inpatient services rendered to each patient based on the DRG to which that patient has been assigned, as determined by multiplying the statewide base price by the applicable service intensity weight (SIW) and facility-specific wage equalization factor (WEF) and as further adjusted for teaching hospitals by the inclusion of reimbursement for direct and indirect graduate medical education (GME) costs and for all hospitals, the inclusion of non-comparable costs.
3. Service intensity weights (SIWs) are the cost weights established such that the SIW for any given DRG indicates the relative cost of the average cost of the patient in the DRG as compared to the average cost of all patients in all DRGs. Weights are developed using cost data from Medicaid fee-for-service, Medicaid managed care and commercial payors as reported to the Statewide Planning and Research Cooperative System (SPARCS).
4. Case mix index (CMI) shall mean the relative costliness of a hospital's case mix relative to the case mix of all other hospitals as reflected in the weighted aggregate SIW for the hospital.
5. Reimbursable operating costs shall mean reported operating costs which relate to the cost of providing inpatient hospital services to Medicaid patients, adjusted for inflation between the base period used to determine the statewide base price and the rate period in accordance with trend factors determined pursuant to the applicable provisions of this Attachment, but excluding the following costs:
  - a. ALC costs;
  - b. Exempt unit costs;
  - c. Transfer costs; and
  - d. High-cost outlier costs.

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6. Graduate medical education (GME).
- a. Direct GME costs shall mean the reimbursable salaries, fringe benefits, non-salary costs and allocated overhead for residents, fellows, and supervising physicians trended to the rate year by the applicable provisions of this Attachment.
- b. Indirect GME costs shall mean an estimate of the costs associated with additional ancillary intensiveness of medical care, more aggressive treatment regimens, and increased availability of state-of-the-art testing technologies resulting from the training of residents and fellows.
7. High-cost outlier costs for payment purposes shall mean 100 percent of the hospital's charges converted to cost using the hospital's most recent ratio of cost-to-charges that exceed the DRG specific high-cost thresholds calculated pursuant to Exclusion of Outlier and Transfer Costs of this Section.
8. Alternate level of care (ALC) services shall mean those services provided by a hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary, consistent with utilization review standards, and are being provided by the hospital and are not otherwise available.
9. Exempt hospitals and units shall mean those hospitals and units that are paid per diem rates of payment pursuant to the provisions of Exempt Units and Hospitals of this Section, rather than receiving per discharge case-based rates of payment.
10. The wage equalization factor (WEF) shall mean the mechanism to equalize hospital salary and fringe benefit costs to account for the differences in the price of labor among hospitals and groups of hospitals.
11. Statewide Base Price shall mean the numeric value calculated pursuant to Statewide Base Price of this Section, which shall be used to calculate DRG case-based payments per discharge as defined in paragraph (2) of this Section.
12. Non-comparable adjustments shall mean those base year costs that are passed through the statewide base price calculation and applied to the case-based rate of payment as an add-on payment. The following shall be considered non-comparable adjustments:
- a. Medicaid costs associated with ambulance services operated by a facility and reported as inpatient costs in the Institutional Cost Report (ICR); and

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- b. Medicaid costs associated with schools of nursing operated by the facility and reported as inpatient costs in the ICR; and
- c. Medicaid costs associated with hospital-based physicians at hospitals designated under the Medicare program as meeting the criteria set forth in §1861(b)(7) of the federal Social Security Act.
13. Transfers. For purposes of transfer per diem payments, a transfer patient shall mean a patient who is not discharged as defined in this Section, is not transferred among two or more divisions of merged or consolidated facilities, is not assigned to a DRG specifically identified as a DRG for transferred patients only, and meets one of the following conditions:
- a. is transferred from an acute care facility reimbursed under the DRG case-based payment system to another acute care facility reimbursed under this system; or
- b. is transferred to an out-of-state acute care facility; or
- c. is a neonate who is being transferred to an exempt hospital for neonatal services.
14. Discharges, as used in this Section, shall mean those inpatients whose discharge from the facility occurred on or after December 1, 2009, and:
- a. the patient is released from the facility to a nonacute care setting;
- b. the patient dies in the facility; or
- c. the patient is transferred to a facility or unit that is exempt from the case-based payment system, except when the patient is a newborn transferred to an exempt hospital for neonatal services and thus classified as a transfer patient pursuant to this Section; or
- d. the patient is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.
15. Arithmetic Inlier Length of Stay (ALOS) shall mean the arithmetic average of the number of days a patient is in the hospital per admission as calculated by counting the number of days from and including the day of admission up to, but not including the day of discharge. The ALOS shall be calculated for each DRG on a statewide basis.
16. General hospital, as used in this Section, shall mean a hospital engaged in providing medical or medical and surgical services primarily to in-patients by or under the supervision of a physician on a twenty-four hour basis with provisions for admission or treatment of persons in need of emergency care and with an organized medical staff and nursing service, including facilities providing services relating to particular diseases, injuries, conditions or deformities.

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17. Charge converter shall mean the ratio of cost to charges using total inpatient costs and total inpatient charges as reported by the hospital in its annual institutional cost reports submitted to the Department.
18. IPRO shall mean the Island Peer Review Organization, Inc., a New York not-for-profit corporation providing health related services.

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**Statewide base price.**

1. For periods on and after December 1, 2009, a statewide average cost per discharge shall be established in accordance with the following:
  - a. Reimbursable Medicaid acute operating costs, excluding costs related to graduate medical education, alternate level of care, exempt units, patient transfers, high-cost outliers, and non-comparables, derived from the base period in paragraph (3);
  - b. Adjust subparagraph (a) for case mix and wage neutrality factors derived from the base period in paragraph (3);
  - c. Divide subparagraph (b) by Medicaid inpatient discharges from the base period in paragraph (3); and
  - d. Adjust subparagraph (c) for inflation between the base period and the rate period in accordance with trend factors determined pursuant to applicable provisions of this Attachment.
  
2. An adjustment will be made to the statewide average cost per discharge, calculated in accordance with subparagraph (1) of this section, to establish a "statewide base price" that generates the same level of total Medicaid payments for the reimbursement of operating costs as total Medicaid payments made for the reimbursement of operating costs during calendar year 2008 subsequent to the exclusion of prior period adjustments and the following reductions:
  - a. One hundred fifty-four million five hundred thousand dollars; and
  - b. Two hundred twenty-five million dollars.

No further reconciliation adjustment to the statewide base price to account for changes in volume or case mix will be implemented.
  
3. For periods on and after December 1, 2009, the "base period" shall be the 2005 calendar year except as noted in subparagraph (a) below and "operating costs" shall be those reported by each facility to the Department prior to July 1, 2009.
  - a. For those hospitals operated by the New York City Health and Hospitals Corporation, the base period shall be for the period ended June 30, 2005, and for those hospitals operated by New York State, excluding the hospitals operated by the State University of New York, the base period shall be the 12-month period ended March 31, 2006.
  - b. Discharges to be used for direct graduate medical education and non-comparable adjustments in accordance with the Definitions section should be 2007.

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**Exclusion of outlier and transfer costs.**

1. In calculating rates pursuant to this Section, high-cost outlier costs from hospitals with ancillary and routine charges schedules shall be excluded from the statewide base price and shall equal 100 percent of the excess costs above the high cost outlier threshold which shall be developed using acute Medicaid operating costs derived from the base period used to calculate the statewide base price. The Medicaid discharges to be applied to the high-cost outlier thresholds shall be those that occurred in the base period used to calculate the statewide base price.
  
2. In calculating rates pursuant to this Section, transfer case costs shall be excluded from the statewide base price by excluding the transfer discharges that occurred in the base period used to calculate the statewide base price, except for those transfer cases that are assigned to a DRG specifically identified as a DRG for transferred patients only.

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**Service Intensity Weights (SIW) and average length-of-stay (LOS).**

1. The table of SIWs and statewide average LOS for each effective period is published on the New York State Department of Health website at: <http://www.health.state.ny.us/> and reflects the cost weights and LOS assigned to each All-Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each APR-DRG indicates the relative cost variance of that APR-DRG classification from the average cost of all inpatients in all APR-DRGs. Such SIWs are developed using three years of Medicaid fee-for-service cost data, Medicaid managed care data and commercial third party payor data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years set forth in paragraph (2) below. Costs associated with hospitals that do not have an ancillary charge structure or associated with hospitals and services exempt from the case payment methodology, and costs associated with statistical outliers are excluded from the SIW calculations.
2. For periods on and after December 1, 2009, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2005, 2006 and 2007 calendar years as submitted to the Department by September 30, 2009.

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**Wage Equalization Factor (WEF).**

1. The statewide base price per discharge shall be adjusted by a facility-specific wage equalization factor (WEF) to reflect differences in labor costs between hospitals. Such WEF adjustment shall be used to adjust for the level of wage and fringe benefit costs for each hospital in accordance with the following:

a. The WEF shall be based on each hospital's occupational mix and wages for registered nurses, licensed practical nurses, surgical technologists, nursing aides, orderlies, attendants and medical assistants as reported and approved by the federal Medicare program, and the hospital's proportion of salaries and fringe benefit costs to total operating costs as reported to the Institutional Cost Report (ICR). The WEF shall be computed as follows:

- i. For all occupations described in paragraph (a), a statewide average salary shall be calculated by dividing the statewide sum of hospitals' total dollars paid by the statewide sum of hospitals' hours paid; and
- ii. For each hospital, an actual weighted average salary shall be calculated by dividing the total dollars paid for such occupations by the total hours paid for such occupations; and
- iii. An initial WEF shall be calculated for each hospital by dividing the hospital-specific actual weighted average salary as calculated pursuant to subparagraph (ii) of this paragraph by the statewide average salary calculated pursuant to subparagraph (i) of this paragraph; and
- iv. The final WEF shall be calculated using the following formula:

$$(1 / ((\text{Labor Share} / \text{initial WEF}) + \text{Non-Labor Share}))$$

where "Labor Share" is calculated by dividing the hospital's total salary cost plus the hospital's total fringe benefits by the hospital's total operating costs as reported in the ICR for the same calendar year used to calculate the statewide base price for the applicable rate period. The "Non-Labor Share" equals 1 less the "Labor Share" of costs.

b. A hospital may submit updated occupational service data as approved by the federal Department of Health and Human Services prior to January 1 of a rate year for use in calculating the WEF in accordance with this Section.

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- c. For those hospitals that are in bankruptcy proceedings in the base year and that have subrogated their labor contracts, the Commissioner shall use the higher of the hospital-specific or regional average WEF. These regions will be consistent with those used in the development of exempt unit cost ceilings.

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Add-ons to the case payment rate per discharge.

Rates of payment computed pursuant to this Attachment shall be further adjusted in accordance with the following:

1. A direct graduate medical education (GME) payment per discharge shall be added to the case payment rates of teaching general hospitals after the application of SIW and WEF adjustments to the statewide base price and shall be calculated for each hospital by dividing the facility's total reported inpatient Medicaid direct GME costs by its total reported Medicaid discharges as defined in the Statewide Base Price Section. Direct GME costs shall be those costs defined in the Definitions Section, derived from the same base period used to calculate the statewide base price for the applicable rate period and trended forward to such rate period in accordance with applicable provisions of this Attachment, and shall be excluded from the cost included in the statewide base price.
2. (a) An indirect GME payment per discharge shall be added to the case payment rates of teaching general hospitals after the application of SIW and WEF adjustments to the statewide base price and shall be calculated by multiplying such rates by the indirect teaching cost percentage determined by the following formula:

$$(1 - (1 / (1 + 1.03(((1 + r)^{0.0405} - 1))))))$$

where "r" equals the ratio of residents and fellows to beds based on the medical education statistics or the hospital for the period ended June 30, 2005, as contained in the survey document submitted by the hospital to the Department as of June 30, 2009, and the staffed beds for the general hospital reported in the 2005 ICR and submitted to the Department no later than June 30, 2009, but excluding exempt unit beds and nursery bassinets.

- (b) Indirect GME costs are those costs defined in the Definitions Section, derived from the same base period used to calculate the statewide base price for the applicable rate period and trended forward to such rate period in accordance with applicable provisions of this Attachment, and shall be excluded from computation of the statewide base price. The amount of such exclusion shall be determined by multiplying the total reported Medicaid costs less reported direct GME costs by the following formula:

$$1.03(((1 + r)^{0.0405} - 1))$$

where "r" equals the ratio of residents and fellows to beds as determined in accordance with subparagraph (a) of this paragraph.

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3. A non-comparable payment per discharge shall be added to case payment rates after the application of SIW and WEF adjustments to the statewide base price and shall be calculated for each hospital by dividing the facility's total reported Medicaid costs for qualifying non-comparable cost categories by its total reported Medicaid discharges as defined in the Statewide Base Price Section. Non-comparable hospital costs are those costs defined in the Definitions Section, derived from the same base period used to calculate the statewide base price for the applicable rate period and trended forward to such rate period in accordance with applicable provisions of this Attachment, and shall be excluded from the cost included in the computation of the statewide base price.

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4. For the rate periods on and after December 1, 2009, additional adjustments to the inpatient rates of payment for eligible general hospitals to facilitate improvements in hospital operations and finances will be made, in accordance with the following:
- a. General hospitals eligible for distributions pursuant to this section shall be those nongovernmental hospitals with total Medicaid discharges equal to or greater than seventeen and one-half percent for 2007.
  - b. For the period December 1, 2009 through March 31, 2010, \$33.5 million dollars shall be allocated to eligible hospitals such that no hospital's reduction in Medicaid inpatient revenue, as a result of the hospital acute care rate methodology changes that are effective December 1, 2009, exceeds 9.7%.
  - c. For periods on or after April 1, 2010, funds distributed pursuant to this section shall be allocated to eligible hospitals based on a proportion of the eligible hospital's allocation of the funds distributed for the period December 1, 2009 through March 31, 2010, to the total funds distributed for that period applied to the appropriate funds available for the applicable periods below:
    - i. for the period April 1, 2010 through March 31, 2011, \$75 million;
    - ii. for the period April 1, 2011 through March 31, 2012, \$50 million; and
    - iii. for the period April 1, 2012 through March 31, 2013, \$25 million.
  - d. Payments made pursuant to this section shall be added to rates of payments and not be subject to retroactive adjustment or reconciliation. The amount per discharge to be added to the rates shall be established by dividing the total allocated funds in accordance with paragraph (b) and (c) by the hospital's total reported Medicaid discharges in the applicable base period.
  - e. Each hospital receiving funds pursuant to this section shall, as a condition for eligibility for such funds, adopt a resolution of the Board of Directors of each such hospital setting forth its current financial condition, including ongoing board oversight, and shall, after two years, issue a report as adopted by each such Board of Directors setting forth what progress has been achieved regarding such improvement, provided, however, if such report fails to set forth adequate progress, as determined by the Commissioner, the Commissioner will deem such facility ineligible for further distributions pursuant to this section and will redistribute such further distributions to other eligible facilities in accordance with the provisions of this section. The Commissioner shall be provided with copies of all such resolutions and reports.

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Outlier and transfer cases rates of payment.

1. a. High cost outlier rates of payment shall be calculated by reducing total billed patient charges, as approved by IPRO, to cost, as determined based on the hospital's ratio of cost to charges. Such calculation shall use the most recent data available as subsequently updated to reflect the data from the year in which the discharge occurred, and shall equal 100 percent of the excess costs above the high cost outlier threshold. High cost outlier thresholds shall be developed for each individual DRG and adjusted by hospital-specific wage equalization factors (WEF) and increased by the U.S. Consumer Price Index for all Urban Consumers from the base period to the rate period used to determine the statewide base price and the rate period.
  
- b. Cost outlier thresholds for each base APR-DRG will be calculated as follows:
  - i. using the applicable base year Medicaid claims data, organize costs per claim within each base APR-DRG from least to greatest value;
  - ii. divide the listing of claims from subparagraph (i) for each base APR-DRG into three quartiles;
  - iii. the first quartile (Q1) is the set of data having the property that at least one-quarter of the observations are less than or equal to Q1 and that at least three-quarters of the data are greater than or equal to Q1;
  - iv. the third quartile (Q3) is conversely identified;
  - v. determine the inter-quartile range (IOR) by identifying the spread of the difference between Q1 and Q3 (IOR = Q3 - Q1);
  - vi. cost outlier thresholds are determined by applying the IOR as follows:

$$[(y) * IOR] + Q3$$

where (y) equals a predetermined standard multiplier. This multiplier is a factor of 5.5.

- c. A non-public, not-for-profit general hospital which has not established an ancillary and routine charges schedule shall be eligible to receive high-cost outlier payments equal to the average of high-cost outlier payments received by comparable hospitals, as determined using the following criteria:
  - i. downstate hospitals;
  - ii. hospitals with a case mix greater than 1.75;
  - iii. hospitals with Medicaid revenue greater than \$30 million; and
  - iv. hospitals with a proportion of outlier to inlier cases greater than 3.0 percent.

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2. Rates of payment to non-exempt hospitals for inpatients who are transferred to another non-exempt hospital shall be calculated on the basis of a per diem rate for each day of the patient's stay in the transferring hospital, subject to the exceptions set forth in paragraphs (a), (b) and (c) of this paragraph. The total payment to the transferring facility shall not exceed the amount that would have been paid if the patient had been discharged. The per diem rate shall be determined by dividing the DRG case-based payment per discharge as defined in the Definitions Section by the arithmetic inlier length of stay (LOS) for that DRG, as defined in the Definitions Section, and multiplying by the transfer case's actual length of stay and by the transfer adjustment factor of 120 percent. In transfer cases where the arithmetic inlier LOS for the DRG is equal to one, the transfer adjustment factor shall not be applied.
- a. Transfers among more than two hospitals that are not part of a merged facility shall be reimbursed as follows:
- i. the facility which discharges the patient shall receive the full DRG payment; and  
ii. all other facilities in which the patient has received care shall receive a per diem rate unless the patient is in a transfer DRG.
- b. A transferring facility shall be paid the full DRG rate for those patients in DRGs specifically identified as transfer DRGs.
- c. Transfers among non-exempt hospitals or divisions that are part of a merged or consolidated facility shall be reimbursed as if the hospital that first admitted the patient had also discharged the patient.
- d. Services provided to neonates discharged from a hospital providing neonatal specialty services to a hospital reimbursed under the case payment system for purposes of weight gain shall be reimbursed and assigned to the applicable APR- DRG upon admission or readmission.

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**Alternate level of care payments (ALC).**

1. Hospitals shall be reimbursed for ALC days at the appropriate 1987 group average operating cost component of rates of payment for hospital-based residential health care facilities established pursuant to Attachment 4.19-D trended to the rate year.

The determination of the group average operating rate for hospital-based residential health care facilities specified in this paragraph shall be based on the combination of residential health care facilities as follows:

- a. The downstate group consisting of residential health care facilities located in the five boroughs of New York City and Nassau, Suffolk, Westchester and Rockland counties.
  - b. The upstate group consisting of all other residential health care facilities in the State.
2. Hospitals that convert medical/surgical beds to residential health care beds shall be reimbursed for services provided in the converted beds in accordance with Attachment 4.19-D.

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**Exempt units and hospitals.**

1. Physical medical rehabilitation inpatient services shall qualify for reimbursement as an exempt unit/hospital pursuant to this paragraph for periods on and after December 1, 2009, only if such services are provided in a hospital specializing in such services or in a distinct unit within a general hospital designated for such services and only if:
  - a. Such hospital or such unit qualified for exempt unit status for purposes of reimbursement under the federal Medicare prospective payment system as of December 31, 2001; or
  - b. On or before July 1, 2009, the hospital submitted a written request to the Department for exempt status providing assurances acceptable to the Department that the hospital or unit within the hospital meets the exempt status for 2009 for periods prior to December 1, 2009.
    - i. For periods on and after January 1, 2010, a hospital seeking exempt status for a hospital or a distinct unit within the hospital not previously recognized by the Department as exempt for reimbursement purposes shall submit a written request to the Department for such exempt status and shall provide assurances and supporting documentation acceptable to the Department that the hospital or unit meets qualifying exempt status criteria in effect at the time such written request is submitted. Approval by the Department of such exempt status shall, for reimbursement purposes, be effective on the January 1 following such approval, provided that the request for such exempt unit status was received at least 120 days prior to such date.
    - ii. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009, not including reported direct medical education costs, and held to a ceiling of 110% of the average of such costs in the region in which the facility is located, as described in paragraph (9) of this section. Such rates shall reflect trend adjustments in accordance with the applicable provisions this Attachment.
2. Chemical dependency rehabilitation inpatient services shall qualify for reimbursement pursuant to this paragraph for periods on and after December 1, 2009, only if such services are provided in a hospital specializing in such services or in a distinct unit within a general hospital designated for such services and only if:

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- a. The services provided in such hospital or unit are limited to chemical dependency rehabilitation care and do not include chemical dependency related inpatient detoxification and/or withdrawal services; or
- b. Such hospital or unit is licensed to provide such services pursuant to both the Public Health Law and the Mental Hygiene Law and meets the applicable alcohol and/or substance abuse rehabilitation standards set forth in regulations;
  - i. Any such unit within a hospital must be in a designated area and consist of designated beds providing only chemical dependency rehabilitation inpatient services with adequate adjoining supporting spaces and assigned personnel qualified by training and/or by experience to provide such services and in accordance with any applicable criteria regarding the provision of such services issued by the New York State Office of Alcohol and Substance Abuse Services.
  - ii. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009, not including reported direct medical education costs, and held to a ceiling of 110% of the average of such costs in the region in which the facility is located, as described in paragraph (9) of this section. Such rates shall reflect trend adjustments in accordance with the applicable provisions of this Attachment.

3. Critical access hospitals.

- a. Rural hospitals shall qualify for inpatient reimbursement as critical access hospitals for periods on and after December 1, 2009, only if such hospitals are designated as critical access hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act.
- b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009, and held to a ceiling of 110% of the average of such costs for all such designated hospitals statewide. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.

4. Cancer hospitals.

- a. Hospitals shall qualify for inpatient reimbursement as cancer hospitals for periods on and after December 1, 2009, only if such hospitals were, as of December 31, 2008, designated as comprehensive cancer hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act.

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- b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this Section shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.
5. Specialty long term acute care hospital.
- a. Hospitals shall qualify for inpatient reimbursement as specialty long term acute care hospitals for periods on and after December 1, 2009, only if such hospitals were, as of December 31, 2008, designated as specialty long term acute care hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act.
- b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this Section shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.
6. Acute care children's hospitals. Hospitals shall qualify for inpatient reimbursement as acute care children's hospitals for periods on and after December 1, 2009, only if:
- a. Such hospitals were, as of December 31, 2008, designated as acute care children's hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act; and
- b. Such hospitals filed a discrete 2007 institutional cost report reflecting reported Medicaid discharges of greater than 50 percent of total discharges.
- i. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2007 operating costs as submitted to the Department prior to July 1, 2009. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.
7. Substance abuse detoxification inpatient services. For patients discharged on and after December 1, 2008, rates of payment for general hospitals which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS) to provide services to patients determined to be in the diagnostic category of substance abuse (MDC 20, DRGs 743 through 751) will be made on a per diem basis. This includes inpatient detoxification, withdrawal, and observation services.

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Medically managed detoxification services are for patients who are acutely ill from alcohol and/or substance related addictions or dependence, including the need or risk for the need of medical management of severe withdrawal, and/or are at risk of acute physical or psychiatric co-morbid conditions. Medically supervised withdrawal services are for patients at a mild or moderate level of withdrawal, or are at risk for such, as well as patients with sub-acute physical or psychiatric complications related to alcohol and/or substance related dependence, are intoxicated, or have mild withdrawal with a situational crisis, or are unable to abstain yet have no past withdrawal complications.

The per diem rates for inpatient detoxification, withdrawal, and observation services will be determined as follows:

- a. The operating cost component of the per diem rates will be computed using 2006 costs and statistics as reported to the Department by general hospitals prior to 2008, adjusted for inflation. The inflation factor will be calculated in accordance with the trend factor methodology described in this Attachment. The average operating cost per diem for the region in which the hospital is located will be calculated using costs incurred for patients requiring detoxification services. The operating cost component of the per diem rates will be transitioned to 2006 as follows:
1. For the period December 1, 2008 through March 31, 2009, 75% of the operating cost component will reflect the operating cost component of rates effective for December 31, 2007, adjusted for inflation, and 25% will reflect 2006 operating costs in accordance with paragraphs (b) through (f).
  2. For April 1, 2009 through March 31, 2010, 37.5% of the operating cost component will reflect the December 31, 2007 operating cost component, adjusted for inflation, and 62.5% will reflect 2006 operating costs in accordance with paragraphs (b) through (f).
  3. For periods on and after April 1, 2010, 100% of the operating cost component will reflect 2006 operating costs in accordance with paragraphs (b) through (f).

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- b. For purposes of establishing the average operating cost per diem by region for medically managed detoxification and medically supervised withdrawal services, the regions of the state are defined as follows:
1. New York City - Bronx, New York, Kings, Queens and Richmond Counties;
  2. Long Island - Nassau and Suffolk Counties;
  3. Northern Metropolitan - Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester Counties;
  4. Northeast - Albany, Clinton, Essex, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties;
  5. Utica/Watertown - Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida Counties;
  6. Central - Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga and Tompkins Counties;
  7. Rochester - Monroe, Ontario, Livingston, Wayne and Yates Counties; and
  8. Western - Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.
- c. For each of the regions, the 2006 operating costs incurred by general hospitals in such region for providing care to inpatients requiring detoxification services, as defined by OASAS, and reported in the 2006 ICR submitted to the Department prior to 2008, are adjusted by a length of stay (LOS) factor. This LOS factor reflects the loss of revenue due to the reduction of payments for services over the 5th day of stay. The total adjusted operating costs for each region, divided by the total regional days, is the average operating cost per diem for the region.
- d. The per diem rates for inpatients requiring medically managed detoxification services will reflect 100% of the average operating cost per diem for the region in which the hospital is located, adjusted for inflation, for the first 5 days of service. However, such payments will be reduced by 50% for services provided on the 6<sup>th</sup> through 10<sup>th</sup> day of service. No payments will be made for any services provided on and after the 11<sup>th</sup> day.
- e. Per diem rates for inpatients requiring medically supervised withdrawal services, will reflect 100% of the average operating cost per diem for the region in which the hospital is located, adjusted for inflation, for the period January 1, 2009 through December 31, 2009. For periods on and after January 1, 2010, the per diem rates for withdrawal services will reflect 75% of the average operating cost per diem for the region, adjusted for inflation, and will be reduced by 50% for care provided on the 6<sup>th</sup> through 10<sup>th</sup> day of service. No payments will be made for any services provided on and after the 11<sup>th</sup> day.

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- f. Per diem rates for inpatients placed in observation beds, as defined by OASAS, will reflect 100% of the average operating cost per diem for the region in which the hospital is located, adjusted for inflation, and will be paid for no more than 2 days of care. After 2 days of care the payments will reflect the patient's diagnosis as requiring either detoxification or withdrawal services. The days of care in the observation beds will be included in the determination of days of care for either detoxification or withdrawal services. Furthermore, days of care provided in observation beds will, for reimbursement purposes, be fully reflected in the computation of the initial five days of care.
- g. Capital cost reimbursement for the general hospitals which are certified by OASAS to provide substance abuse services will be based on the current reimbursement methodology for determining allowable capital for exempt unit per diem rates. Such capital cost will be added to the applicable operating cost component as a per diem amount to establish the per diem rate for each service.

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8. Hospitals or distinct units of hospitals that fail to maintain qualifying criteria for exempt status for reimbursement purposes, as set forth in this Attachment, shall continue to be reimbursed in accordance with such exempt status until the commencement of the next rate period, as determined by the Department.
9. Rates of payment for inpatient services described in paragraphs (1) and (2) above, which utilize regional averages for determining a cost ceiling shall utilize regions of the State set forth below, except that if the otherwise applicable region has less than five exempt hospitals or units in the service, facilities located in the nearest regions will be used to establish a minimum of five hospital or units for the purpose of determining ceilings. Such regions are as follows:
- a. New York City, consisting of the counties of Bronx, New York, Kings, Queens and Richmond;
  - b. Long Island, consisting of the counties of Nassau and Suffolk;
  - c. Northern Metropolitan, consisting of the counties of Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester;
  - d. Northeast, consisting of the counties of Albany, Clinton, Essex, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington;
  - e. Utica / Watertown, consisting of the counties of Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida;
  - f. Central, consisting of the counties of Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga and Tompkins;
  - g. Rochester, consisting of the counties of Monroe, Ontario, Livingston, Wayne and Yates; and
  - h. Western, consisting of the counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.
10. Capital cost components of per diem rates determined pursuant to this Section shall be computed on the basis of budgeted capital costs allocated to the exempt hospital or distinct unit of a hospital pursuant to the capital cost provisions of this Attachment divided by exempt hospital or unit patient days reconciled to actual total expense.

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11. New hospitals and new hospital units. The operating cost component of rates of payment for new hospitals, or hospital units, without adequate cost experience shall be computed based on either budgeted cost projections, subsequently reconciled to actual reported cost data, or the regional ceiling calculated in accordance with paragraph (10) of this section, whichever is lower. The capital cost component of such rates shall be calculated in accordance with the capital cost provisions of this Attachment.

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**Trend factor.**

1. The trend factor terms used in this section will be used to develop rates of payments on or after December 1, 2009.
2. The Commissioner shall establish trend factors for hospitals to project the effects of price movements on historical operating costs. Rates of payment excluding capital, as calculated pursuant to the provisions of this Attachment, shall be trended to the applicable rate year by the trend factors developed in accordance with the provision of this section for rate periods through March 31, 2000.
3. The methodology for establishing the trend factors shall be developed by a panel of four independent consultants with expertise in health economics or reimbursement methodologies for health-related services appointed by the Commissioner.
4. The methodology shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for non-supervisory employees. For 1996 through December 31, 1999, the Commissioner shall apply the 1995 trend factor methodology.
5. The Commissioner shall implement one interim adjustment to the trend factors, based on recommendations of the panel, and one final adjustment to the trend factors. Such adjustment shall reflect the price movement in the labor and non labor components of the trend factor. At the same time adjustments are made to the trend factors in accordance with this subdivision, adjustments shall be made to all inpatient rates of payment affected by the adjusted trend factor.
6. Trend factors used to project reimbursable operating costs to the rate period April 1, 1995 to December 31, 1995 shall not be applied in the development of the rates of payment. This section shall not apply to trend factors, adjusted trend factors or final trend factors used for the January 1, 1995 to December 31, 1995, rate period for purposes of projecting allowable operating costs to subsequent rate periods.
7. Trend factors used to project reimbursable operating costs to the rate period commencing April 1, 1996 through March 31, 1997, shall not be applied in the development of the rates of payment. This section shall not apply to trend factors or final trend factors used for the January 1, 1995 through December 31, 1995 or January 1, 1996 to March 31, 1996, rate period for purposes of projecting allowable operating costs to subsequent rates periods.

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8. Trend factors used to project reimbursable operating costs to rate periods commencing July 1, 1999 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, shall reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.
9. For rate periods on and after April 1, 2000, the Commissioner shall establish trend factors for rates of payment for hospitals to project for the effects of inflation. The factors shall be applied to the appropriate portion of reimbursable costs calculated pursuant to this Attachment.
  - a. In developing trend factors for such rates of payment, the Commissioner shall use the most recent Congressional Budget Office estimate of the rate year's U.S. Consumer Price Index for all Urban Consumers published in the Congressional Budget Office Economic and Budget Outlook after June first of the rate year prior to the year for which rates are being developed.
  - b. After the final U.S. Consumer Price Index (CPI) for all Urban Consumers is published by the United States Department of Labor, Bureau of Labor Statistics, for a particular rate year, the Commissioner shall reconcile such final CPI to the projection used in subparagraph (a) and any difference will be included in the prospective trend factor for the current year.
  - c. At the time adjustments are made to the trend factors in accordance with this section, adjustments shall be made to all inpatient rates of payment affected by the trend factor adjustment.
10. The final 2006 trend factor shall be the U.S. CPI for all Urban Consumers, as published in the U.S. Department Labor Statistics, minus 0.25%.
11. The final 2007 trend factor shall equal 75% of the final trend factor determined in paragraph (b) above.
12. The applicable trend factor for the 2008 and 2009 calendar year periods shall be zero.
13. The applicable trend factor for the 2010 calendar year shall be zero for inpatient services provided by general hospitals [services provided] on and after January 1, 2010.

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**Capital expense reimbursement.**

1. The allowable costs of fixed capital including but not limited to depreciation, rentals and interest on capital debt or, for hospitals financed pursuant to Article 28-B of the Public Health Law, amortization in lieu of depreciation, and interest and other approved expenses associated with both fixed capital and major movable equipment) and major movable equipment shall be reimbursed based on budgeted data and shall be reconciled to total actual expense for the rate year and shall be determined and computed in accordance with the provisions of paragraphs (7) and (8) of this section.
2. General hospitals shall submit a budgeted schedule of anticipated inpatient capital-related expenses for the forthcoming year to the Commissioner at least 120 days prior to the beginning of the rate year.
3. The following principles shall apply to budgets for inpatient capital-related expenses:
  - a. The basis for determining capital-related inpatient expenses shall be the lesser of actual cost or the final amount specifically approved for construction of the capital asset.
  - b. Any capital-related inpatient expense generated by a capital expenditure which requires or required approval pursuant to the Hospitals section of the Public Health Law, must have received such approval for the capital-related expense to be included in the rate calculation.

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- c. The submitted budget may include the capital-related inpatient expense of all existing capital assets, as well as estimates of capital-related inpatient expenses for capital assets to be acquired or placed in use prior to the commencement of the rate year.
- d. Any capital-related expense generated by a capital expenditure acquired or placed in use during a rate year shall be carried forward to the subsequent rate year, provided all required approvals have been obtained. In instances where such approvals have been obtained or where approval is not required and such assets are acquired or placed in use during a rate year, the budget may include estimates for capital-related expenses relating to these assets.
4. Allocation of budgeted capital costs. In each rate year budgeted capital costs shall be allocated to exempt units and hospitals (including certified substance abuse detoxification services) and DRG case payment rates based on reported capital statistics for the year two years prior to the rate year.

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5. Payment for budgeted allocated capital costs.

- a. Capital per diems for exempt units and hospitals shall be calculated by dividing the budgeted capital costs allocated to such rates pursuant to paragraph (4) above by budgeted exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital-approved capital expense.
- b. Capital payments for APR-DRG case rates shall be determined by dividing the budgeted capital allocated to such rates pursuant to paragraph (4) above by the hospital's budgeted, nonexempt unit discharges, reconciled to rate year discharges and actual rate year nonexempt unit or hospital-approved capital expense.
- c. Capital payments for transferred patients shall be determined by dividing the budgeted capital allocated to the APR-DRG case rate by the hospital's budgeted non-exempt unit days, reconciled to rate year days and actual rate year non-exempt unit or hospital approved capital expense.

6. Depreciation.

- a. Reported depreciation based on historical cost is recognized as a proper element of cost. Useful lives shall be the higher of the reported useful life or those useful lives from the Estimated Useful Lives of Depreciable Hospital Assets, American Hospital Association, consistent with title XVIII provisions. Copies of this publication are available from the American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611, and a copy is available for inspection and copying at the offices of the Records Access Officer of the Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.
- b. In the computation of rates for voluntary facilities, depreciation shall be included on a straight line method on plant and non-movable equipment. Depreciation on movable equipment may be computed on a straight line method, or accelerated under a double declining balance, or sum-of-the-years' digit method. Depreciation shall be funded unless the Commissioner determines, upon application by the facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only for capital expenditures with approval as required for the amortization of capital indebtedness. Funding for plant and fixed equipment shall mean that the transfer of monies to the funded accounts shall

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occur by the end of the fiscal period in which the depreciation is recorded. Board-designated funds and the accrual of liabilities to the funded depreciation accounts (due to/from accounts) shall not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts to be considered as valid funding transactions unless expended for the purpose for which it was funded. Failure to meet the funding requirements will result in a reduction amount reimbursed for depreciation equal to the unfunded amount.

- c. In the computation of rates for public facilities, depreciation is to be included on a straight-line method on plant and non-movable equipment. Depreciation on movable equipment may be computed on a straight-line method, or accelerated under a double declining balance or sum-of-the-years' digits method.
- d. Medical facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law shall conform to the requirements of this Subpart. In lieu of depreciation and interest, on the loan-financed portion of the facilities, the Commissioner shall allow level debt service on the mortgage loan, for all loans approved for financing prior to January 1, 1990, together with such required fixed charges, sinking funds and reserves as may be determined by the Commissioner as necessary to assure repayment of the mortgage indebtedness. For loans approved for financing on or after January 1, 1990, medical facilities shall receive reimbursement in the form of interest and depreciation in accordance with the remainder of this Attachment.

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7. Interest.

- a. Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities.
- b. To be considered as an allowable cost, interest shall be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner has been obtained. Financial need for capital indebtedness relating to a specific project shall exist when all available restricted funds designated for capital acquisition of that type have been considered for equity purposes.
- c. Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, trustee malpractice insurance funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense. Investment income shall be defined as the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss shall not be allowable. Rate year investment income shall reduce rate year interest expense allowed for reimbursement as follows:
- i. for all medical facilities, investment income shall first be used to reduce operating interest expense for that year;
- ii. any remaining amount of investment income, after application of paragraph (i), shall be used to reduce capital interest expense reimbursed that year for medical facilities; and

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- iii. any remaining amount of investment income after application of paragraph (ii) shall not be considered in the determination of allowable costs.
- d. Interest on current indebtedness shall be treated and reported as an operating, administrative expense.
- e. Interest on capital indebtedness is an allowable cost if the debt generating the interest is approved by the Commissioner, incurred for authorized purposes, and the principal of the debt is the lesser of the approval of the Commissioner or the cost of the authorized purposes. Capital indebtedness shall mean all debt obligations of a facility that are:
- i. evidenced by a mortgage note or bond and secured by a mortgage on the land, building or non-movable equipment; a note payable secured by the non-movable equipment of a facility; a capital lease;
- ii. incurred for the purpose of financing the acquisition, construction or renovation of land, building or non-movable equipment;
- iii. found by the Commissioner to be reasonable, necessary and in the public interest with respect to the facility. Interest related to refinancing indebtedness shall be considered an allowable cost only to the extent that it is payable with respect to an amount equal to the unpaid principal of the indebtedness then being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of the refinanced indebtedness will be allowable on acceptable demonstration to the Commissioner that such refinancing will result in a debt service savings over the life of the indebtedness; or
- iv. incurred for the purpose of advance refunding of debt. Gains and losses resulting from the advanced refunding of debt shall be treated and reported as a deferred charge or asset. This deferred charge or asset is to be amortized on a straight-line basis over the period to the scheduled maturity date of the refunding debt.
- f. Where a public finance authority has established a mortgage rate of interest such that sufficient cash flows exist to retire the mortgage prior to the stated maturity, the amount of the mortgage to be forgiven, at the time of such forgiveness, shall be capitalized as a deferred asset and amortized over the remaining mortgage life, as a reduction to the facility's capital expense.

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g. Voluntary facilities shall report mortgage obligations financed by public finance authorities for their benefit and which they are responsible to repay, as liabilities in the general fund, when such mortgage obligations are incurred.

8. Sales, leases and realty transactions.

a. If a medical facility is sold, leased, or is the subject of any other realty transaction before a rate for the facility has been determined and certified by the Commissioner, the capital cost component of such rate shall be determined in accordance with the provisions of this Section.

b. If a medical facility is sold, leased, or is the subject of any other realty transaction after a rate for the facility has been determined and certified by the Commissioner, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realty transaction had not occurred. This paragraph shall not be construed as limiting the powers and rights of the Commissioner to change rate computations generally or specifically when based upon previous error, deceit or any other misrepresentation or misstatement that has led the commissioner to determine and certify a rate which he would otherwise not have determined or certified. Further, this paragraph shall not be construed as limiting the powers and rights of the commissioner to reduce rates when one or more of the original property right aspects related to such a facility is terminated.

c. An arms length lease purchase agreement with a non-related lessor involving plant facilities or equipment which meets any one of the four following conditions, establishes the lease as a virtual purchase.

i. The lease transfers title of the facilities or equipment to the lessee during the lease term.

ii. The lease contains a bargain purchase option.

iii. The lease term is at least 75 percent of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment.

iv. The present value of the minimum lease payments (payments to be made during the lease term including bargain purchase option, guaranteed residual value and penalties for failure to renew) equals at least 90 percent of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. Present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is

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less than the lessee's incremental borrowing rate, in which case the interest rate implicit in the lease is used.

- d. If a lease is established as a virtual purchase under paragraph (c), the rental charge may be included in capital-related costs to the extent that it does not exceed the amount that the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership). The cost of ownership shall be limited to depreciation and interest. Further, the amounts to be included in capital-related costs are determined as follows:
- i. The difference between the amount of rent paid and the amount of rent allowed as capital-related costs is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.
  - ii. If an asset is returned to the owner instead of being purchased, the deferred charge may be included in capital-related costs in the year the asset is returned.
  - iii. If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership.
  - iv. If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to a fair rental value.
  - v. If the lessee becomes the owner of the leased asset (either by operation of the lease or by other means), the amount considered as depreciation for the purpose of having computed the limitation on rental charges under this paragraph, must be used in calculating the limitation on adjustments for the purpose of determining any gain or loss upon disposal of an asset.
  - vi. In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs had the provider legal title to the asset.

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- e. If a facility enters into a sale and leaseback agreement involving plant facilities or equipment, the amounts to be included in capital-related costs both on an annual basis and over the useful life of the asset shall not exceed the costs of ownership which shall be limited to depreciation and interest, and shall be determined as follows:
- i. If the annual rental or lease costs in the early years of the lease are less than the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are more than the annual costs of ownership, in the years that the annual rental or lease costs are more than the annual costs of ownership, the facility may include in capital-related costs annually the actual amount of rental or lease costs, except that in any given year, the amount included in capital related costs is limited to an amount which would not cause the aggregate rental or lease costs included up to that year in capital-related costs to exceed the costs of ownership that would have been included in capital-related costs up to that year if the provider had retained legal title to the asset.
  - ii. If the annual rental or lease costs in the early years of the lease exceed the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are less than the annual costs of ownership, the facility may carry forward amounts of rental or lease costs that were not included in capital-related costs in the early years of the lease due to the costs of ownership limitation, and include these amounts in capital-related costs in the years of the lease when the annual rental or lease costs are less than the annual costs of ownership, provided, however, in any given year the amount of actual annual rental or lease costs plus the amount carried forward to that year may not exceed the amount of the costs of ownership for that year.
  - iii. In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs if the provider had retained legal title to the asset.
  - iv. If a facility enters into a sale and leaseback agreement involving land, the incurred rental for the cost of land may not be included in allowable costs.

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**Reimbursable Assessment for Statewide Planning and Research Cooperative System (SPARCS).**

The Commissioner will inform each such hospital of its actual fee to support the statewide planning and research cooperative system and each hospital will submit such fee on a quarterly basis to be received by the Commissioner no later than the 15th of February, May, August and November of each year. Failure to submit such fees in accordance with this schedule will result in a one-percent reduction in the affected hospital's rate beginning on the first day following the due date and continuing until the last day of the calendar month in which said fees are submitted.

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**Federal upper limit compliance.**

1. In the event the State cannot provide assurances satisfactory to the Secretary of the Department of Health and Human Services related to a comparison of rates of payment for general hospital inpatient services to beneficiaries of the Title XIX program in the aggregate to maximum reimbursement payments provided in Federal law and regulation for purposes of securing Federal financial participation in such payments, such rates of payments shall be adjusted proportionally as necessary to meet Federal requirements for securing Federal financial participation.

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Adding or deleting hospital services or units.

1. Notification of the elimination of a general hospital inpatient service or identifiable unit of such a service in instances in which the costs of such service are reflected in the rate calculated pursuant to this Section shall be submitted in writing by the facility to the Department within 60 days of the elimination of such service or unit. If a rate is modified by the Department as a result of such service or unit elimination, such rate shall be effective as of the date of the elimination of the service or unit.
  
2. Notification of the establishment of a new hospital or of a new exempt unit of an existing hospital shall be submitted in writing by the facility to the Department within 60 days of the establishment of such new hospital or such new unit. Thereafter the Department shall establish inpatient rates for such new hospital or such new exempt unit in accordance with the provisions of this Attachment. Such rates shall be effective the first day of the month following 30 days after such notification or the date of the approved certificate of need (CON) certification, whichever is later.

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New hospitals and hospitals on budgeted rates.

1. New hospitals. Payments to new hospitals without adequate cost experience for inpatient acute care services that are not exempt from DRG case-based rates of payment shall be computed in accordance with this Attachment except as follows:
  - a. Rates of payment shall be computed on the basis of 100 percent of the statewide base price multiplied by the service intensity weight for each DRG as determined and set forth with the provisions of this Attachment.
  - b. The WEF used to adjust the statewide base price shall be equal to 1.0 until adequate data becomes available.
  - c. The non-comparable operating costs of new facilities as defined in the Definitions Section and direct graduate medical education costs shall consist of the hospital's budgeted operating costs for these services.
2. Hospitals on Budgeted Rates. Payments to hospitals without adequate cost experience whose rates are based on budgeted cost projections for inpatient acute care services that are not exempt from DRG case-based rates of payment shall be computed in accordance with this Subpart except as follows:
  - a. Reimbursement for the costs of graduate medical education and non-comparable services shall be calculated pursuant to the provisions of paragraph (1)(c) above.
  - b. The WEF used shall be calculated for the facility based on available historical data.

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Swing bed reimbursement.

1. Definitions.

- a. For purposes of this Section, a swing bed program operated by a rural hospital that has an approval from the Centers for Medicare and Medicaid Services (CMS) to provide post-hospital skilled nursing facility (SNF) care, shall mean beds used interchangeably as either general hospital or nursing home beds with reimbursement based on the specific type of care provided so that use of beds in this manner provides small hospitals with greater flexibility in meeting fluctuating demands for inpatient general hospital and nursing home care.
- b. Rate shall mean the aggregate governmental payment made to eligible facilities per patient day as defined in Attachment 4.19-D for the care of patients receiving care pursuant to Title XIX of the federal Social Security Act (Medicaid).

2. Rates of payment.

Payments to eligible hospitals for patient days resulting from the usage of swing beds in caring for patients for whom it has been determined that inpatient hospital care is not medically necessary, but that skilled nursing or health related care is required, shall be determined as follows:

- a. The operating component of the rate shall consist of the following:
  - i. a direct component which shall be equivalent to the 1988 statewide average direct case mix neutral cost per day for hospital-based residential health care facilities, after application of the Regional Direct Input Price Adjustment Factor (RDIPAF) as determined pursuant to Attachment 4.19-D, adjusted for inflation with trend factors determined pursuant to the applicable provisions of Attachment 4.19-A;
  - ii. an indirect component which shall be equivalent to the 1988 statewide average indirect cost per day for hospital-based residential health care facilities, after application of the RDIPAF pursuant to Attachment 4.19-D, adjusted for inflation with trend factors determined pursuant to the applicable provisions of Attachment 4.19-A; and
  - iii. a non-comparable component which shall be equivalent to the 1988 statewide average non-comparable cost per day for hospital-based residential health care facilities, adjusted for inflation with trend factors determined pursuant to the applicable provisions of Attachment 4.19-A.

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- b. For general hospitals with more than 49 beds, the maximum number of days for which the operating component of the rate as defined in this Attachment shall be paid shall be equivalent to fifteen (15) percent of a hospital's total annual patient days for acute, exempt unit, and alternate level of care services, excluding swing bed days.
- c. The operating component of the rate as defined in this Attachment shall be paid for the first sixty (60) days per year during which a patient is receiving care as a participant in the swing bed program. Any patient stay in excess of sixty (60) days per year shall be reimbursed at the prevailing average rate paid for the care of Alternate Level of Care (ALC) patients pursuant to the Alternate Level of Care Payments provisions of this Attachment. The sixty-day period shall begin the first day on which the patient receives care as a participant in the swing bed program.
- d. A capital cost per diem shall be paid on the basis of budgeted capital costs allocated to the swing bed program, pursuant to the capital cost provisions of this Attachment, divided by patient days associated with the swing bed program, reconciled to actual total capital expense.

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Mergers, acquisitions and consolidations.

1. Rates of Payment. As used in this Section, the terms merger, acquisition and consolidation shall mean the combining of two or more general hospitals where such combination is consistent with the public need, would create a new, more economical entity, reduce the costs of operation, result in the reduction of beds and/or improve service delivery and approved through the Department's Certificate of Need process. Payments for hospitals subject to a merger, acquisition or consolidation for inpatient acute care services that are not otherwise exempt from DRG case-based rates of payment will be effective on the date the transaction is effected and shall be computed in accordance with this Section except as follows:

- a. The WEF used to adjust the statewide base price shall be calculated by combining all components used in the calculation pursuant to the WEF Section for all hospitals subject to the merger, acquisition or consolidation.
- b. The direct GME payment per discharge added to the case payment rates of teaching hospitals shall be calculated by dividing the total reported Medicaid direct GME costs for all teaching hospitals subject to the merger, acquisition, or consolidation by the total reported Medicaid discharges reported by such hospitals in the applicable base period.
- c. The indirect GME payment per discharge added to the case payment rates of teaching hospitals shall be calculated in accordance with the Add-ons to the Case Payment Rate Per Discharge Section, except the ratio of residents to beds used in the calculation shall be based on the total residents and beds of all such hospitals subject to the merger, acquisition, or consolidation.
- d. The non-comparable payment per discharge added to the case payment rates shall be calculated by dividing the total reported Medicaid costs for qualifying non-comparable cost categories for all hospitals subject to the merger, acquisition, or consolidation by the total reported Medicaid discharges reported by such hospitals in the applicable base period.

2. Temporary rate adjustment.

- a. The Commissioner may grant approval of a temporary adjustment to rates calculated pursuant to this Section for hospitals subject to mergers, acquisitions or consolidations occurring on or after the year the rate is based upon, provided such hospitals demonstrate through submission of a written proposal that the merger, acquisition or consolidation will result in an improvement to (i) cost effectiveness of service delivery, (ii) quality of care, and (iii) other factors deemed appropriate by the Commissioner. Such written proposal shall be submitted to the Department sixty days prior to the requested effective date of the temporary rate adjustment. The temporary rate adjustment shall consist of the various rate components of the surviving entity for a specified amount of time as approved by the Commissioner. At the end of the specified timeframe, the hospital will be reimbursed in accordance with the statewide methodology.

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- b. The Commissioner shall withdraw approval of a temporary rate adjustment for hospitals which (i) fail to demonstrate compliance with and continual improvement on the approved proposal or (ii) an update to the base year is made by the Department.

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**Administrative rate appeals**

1. Administrative rate appeals of rates of payment issued pursuant to this Attachment must be submitted to the Department in writing within 120 days of the date such rates are issued by the Department to the facility. Such rate appeals must set forth in detail the basis for such appeal and be accompanied by any relevant documentation. Thereafter the Department shall respond to such rate appeals in writing and shall either affirm the original rates, revise such rates or request additional information. A failure to respond to the Department's request for additional information within 30 days shall be deemed to constitute the withdrawal, with prejudice, of the facility's rate appeal, provided, however, that the Department may extend that time period upon a request by the facility and for good cause shown. Upon its receipt of the requested additional information the Department shall issue a written determination of such rate appeal.
2. The Department's written determination of a facility's rate appeal shall be deemed final unless the facility submits a written request for further consideration of the rate appeal within 30 days of the date the Department issued such written determination, provided, however, that if such written determination advises the facility that its rate appeal is being denied on the ground that the appeal constitutes a challenge to the rate-setting methodology set forth in this Attachment, such denial shall be deemed to be the Department's final administrative determination with regard to such appeal and there shall be no further administrative review available. The Department shall otherwise respond in writing to such further appeal and either affirm or revise its original rate appeal determination and this response by the Department shall be deemed its final administrative determination with regard to such rate appeal.
3. Rate appeals which are rejected or precluded on the grounds of being untimely may be considered in connection with subsequent audits conducted pursuant to the audit provisions of this Attachment.
4. The Department shall consider only those rate appeals that reflect one or more of the following bases.
  - a. Mathematical or clerical errors in the financial and/or statistical data originally submitted by the medical facility, including information reported to the New York State Statewide Planning and Research Cooperate System (SPARCS), or mathematical or clerical errors made by the Department. Revised data submitted by a facility must meet the same certification requirements as the original data and the Department may require verification of revised SPARCS data by an independent review agent at the cost of the facility; and

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- b. Any errors regarding a medical facility's capital cost reimbursement.
5. The Department may refuse to accept or consider a rate appeal from a facility that:
- a. is providing an unacceptable level of care as determined after review by the State Hospital review and Planning Council; or
  - b. is operated by the same management that operates a facility with regard to which a determination of an unacceptable level of care has been made in accordance with paragraph (a) of this subdivision; or
  - c. has been determined by the Department as being operated by a person or persons not properly established or licensed pursuant to the Public Health Law; or
  - d. is delinquent in the payment of a fine or penalty imposed on the facility pursuant to the Public Health Law.
6. Any hospital whose Medicaid inpatient rates are subject to this Subpart and which is determined by the federal Department of Health and Human Services to be no longer eligible for reimbursement pursuant to Title XVIII (Medicare) of the federal social security act shall not be eligible for reimbursement by Medicaid until re-certification of the facility by the federal Department of Health and Human Services as eligible for reimbursement pursuant to Title XVIII of the federal Social Security Act.

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Out-of-state providers.

1. For discharges occurring on and after December 1, 2009, rates of payment for inpatient hospital services provided by out-of-state providers in accordance with the prior approval requirements shall be as follows:
  - a. the weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals located in the downstate region of New York State shall apply with regard to services provided by out-of-state providers located in the New Jersey counties of Sussex, Passaic, Bergen, Hudson, Essex, Union, Middlesex and Monmouth, in the Pennsylvania county of Pike, and in the Connecticut counties of Fairfield and Litchfield; and
  - b. the weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals located in the upstate region of New York State shall apply with regard to all other out-of-state providers.
2. Notwithstanding any inconsistent provision of this Section, in the event the Department determines that an out-of-state provider is providing services that are not available within New York State, the Department may negotiate payment rates and conditions with such provider; provided however, such payments shall not exceed the providers usual and customary charges for such services.
3. For purposes of this Section, the downstate region of New York State shall consist of the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess, and the upstate region of New York State shall consist of all other New York counties.

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**Supplemental indigent care distributions.**

1. From funds in the pool for each year, except as otherwise provided for in this section, \$27 million shall be reserved on an annual basis for the periods January 1, 2000 through May 1, 2009, to be distributed to each hospital based on each hospital's proportional annual reduction to their projected distribution from the New York State Health Care Reform Act Profession Education Pool, relative to the statewide annual reduction to said pool, as authorized by State law, up to the hospital specific disproportionate share (DSH) payment limits.
2. Effective May 1, 2009 through December 31, 2009:
  - a. Each hospital eligible for supplemental indigent care distributions in 2008 shall receive 90% of its 2008 annual award amount as Medicaid DSH payment.
  - b. \$307 million shall be distributed to facilities designated by the Department as teaching hospitals as of December 31, 2008, to compensate such facilities for Medicaid and self-pay losses. The payment amounts apply consistently to all teaching hospitals, and are reasonably related to costs, based on Medicare GME payments as a proxy, and are pursuant to the following schedule of payments:

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<u>Hospital</u>	<u>Calendar Year 2009</u>
	<b>\$ 307,000,000</b>
	<b>Uninsured Distribution to Teaching Hospitals</b>
ALBANY MEDICAL CENTER HOSPITAL	\$ 7,207,099
ST PETERS HOSPITAL	\$ 1,001,662
ALBANY MEDICAL CENTER SOUTH CLINICAL CAMPUS	\$ 3,880
UNITED HEALTH SERVICES, INC	\$ 1,140,730
OLEAN GENERAL HOSPITAL	\$ 24,817
ERIE COUNTY MEDICAL CENTER	\$ 597,922
MERCY HOSPITAL OF BUFFALO	\$ 319,739
ROSWELL PARK MEMORIAL INSTITUTE	\$ 1,652,987
KALEIDA HEALTH	\$ 4,938,527
HIGHLAND HOSPITAL OF ROCHESTER	\$ 2,845,852
ROCHESTER GENERAL HOSPITAL	\$ 3,553,825
STRONG MEMORIAL HOSPITAL	\$ 11,695,895
THE UNITY HOSPITAL OF ROCHESTER	\$ 572,019
GLEN COVE HOSPITAL	\$ 471,540
WINTHROP UNIVERSITY HOSPITAL	\$ 6,071,885
SOUTH NASSAU COMMUNITIES HOSPITAL	\$ 530,429
NASSAU UNIVERSITY MEDICAL CENTER	\$ 1,783,090
NORTH SHORE UNIVERSITY HOSPITAL	\$ 13,118,952
ST FRANCIS HOSPITAL OF ROSLYN	\$ 425,667
ST ELIZABETH MEDICAL CENTER	\$ 7,889
FAXTON - ST LUKE'S HEALTHCARE	\$ 23,436
COMMUNITY-GENERAL HOSPITAL OF GREATER SYRACUSE	\$ 196,351
ST JOSEPHS HOSPITAL HEALTH CENTER	\$ 2,697,040
UNIVERSITY HOSPITAL SUNY HEALTH SCIENCE CENTER	\$ 6,987,635
CROUSE HOSPITAL	\$ 958,865
MARY IMOGENE BASSETT HOSPITAL	\$ 472,619
ELLIS HOSPITAL	\$ 960,657
ST CHARLES HOSPITAL	\$ 249,445
UNIVERSITY HOSPITAL AT STONY BROOK	\$ 13,197,922
HUNTINGTON HOSPITAL	\$ 64,200
GOOD SAMARITAN HOSPITAL OF WEST ISLIP	\$ 589,318

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BENEDICTINE HOSPITAL	\$ 459,898
KINGSTON HOSPITAL	\$ 430,512
MOUNT VERNON HOSPITAL	\$ 115,045
SOUND SHORE MEDICAL CENTER	\$ 155,810
WESTCHESTER MEDICAL CENTER	\$ 16,611,342
BRONX-LEBANON HOSPITAL CENTER	\$ 37,193
JACOBI MEDICAL CENTER	\$ 2,082,896
MONTEFIORE HOSPITAL & MEDICAL CENTER	\$ 24,605,332
LINCOLN MEDICAL & MENTAL HEALTH CENTER	\$ 3,019,391
NORTH CENTRAL BRONX HOSPITAL	\$ 754,891
BROOKLYN HOSPITAL	\$ 5,938,856
CONY ISLAND HOSPITAL	\$ 995,496
KINGS COUNTY HOSPITAL CENTER	\$ 3,882,475
LONG ISLAND COLLEGE HOSPITAL	\$ 3,448,174
NY METHODIST HOSPITAL OF BROOKLYN	\$ 3,807,310
KINGSBROOK JEWISH MEDICAL CENTER	\$ 121,313
WYCKOFF HEIGHTS HOSPITAL	\$ 1,230,117
STATE UNIVERSITY HOSPITAL DOWNSTATE MEDICAL CENTER	\$ 4,116,253
WOODHULL MEDICAL AND MENTAL HEALTH CENTER	\$ 876,601
INTERFAITH MEDICAL CENTER	\$ 831,511
BELLEVUE HOSPITAL CENTER	\$ 2,636,659
BETH ISRAEL MEDICAL CENTER	\$ 12,615,285
HARLEM HOSPITAL CENTER	\$ 2,002,465
HOSPITAL FOR SPECIAL SURGERY	\$ 3,247,177
LENOX HILL HOSPITAL	\$ 12,658,212
MANHATTAN EYE EAR AND THROAT	\$ 416,294
MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISEASES	\$ 5,831,787
METROPOLITAN HOSPITAL CENTER	\$ 1,570,125
MOUNT SINAI HOSPITAL	\$ 18,689,832
NY EYE AND EAR INFIRMARY	\$ 407,797
ST LUKES - ROOSEVELT HOSPITAL CENTER	\$ 8,823,583
SVCMC ST VINCENTS-MANHATTAN	\$ 5,342,595
GOLDWATER MEMORIAL HOSPITAL	\$ 10,006
COLER MEMORIAL HOSPITAL	\$ 639
NYU HOSPITALS CENTER	\$ 13,483,008

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NEW YORK PRESBYTERIAN HOSPITAL	\$	27,337,202
ELMHURST HOSPITAL	\$	2,226,463
JAMAICA HOSPITAL	\$	1,185,404
LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER	\$	18,206,316
QUEENS HOSPITAL CENTER	\$	554,077
NY MED CTR OF QUEENS	\$	3,178,354
FOREST HILLS HOSPITAL	\$	1,334,742
STATEN ISLAND UNIVERSITY HOSPITAL	\$	5,084,762
RICHMOND UNIVERSITY MEDICAL CENTER	\$	2,274,908

- c. \$16 million shall be proportionally distributed to non-teaching hospitals based on their proportion of uninsured losses as determined according to the methodology contained in the High Need Indigent Care Adjustment Pool of this Attachment.
- d. Effective December 1, 2009, \$25 million shall be distributed to non-major public hospitals having Medicaid discharges of 40% or greater from data reported in each hospital's 2007 annual cost report, based on each hospital's decrease in Medicaid revenues resulting from the reductions in trend factors for 2008 and 2009 as contained in this Attachment and the inpatient and outpatient reimbursement methodology changes effective December 1, 2009.

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3. For annual periods beginning on and after January 1, 2010:

- a. From regional allotments specified below, \$269.5 million shall be distributed to non-major public teaching hospitals on a regional basis to cover each eligible facility's proportional regional share of 2007 uncompensated care, as defined in the disproportionate share payment calculation provisions of this Attachment and offset by disproportionate share payments received by each facility during calendar year 2010 in accordance with the disproportionate share payment calculations provisions of this Attachment.

<u>Region</u>	<u>Revised Regional Distribution</u>
Long Island	\$ 31,171,915
New York City	\$ 181,778,400
Northern Metropolitan	\$ 14,526,351
Northeast	\$ 8,130,067
Utica/Watertown	\$ 502,271
Central	\$ 10,052,989
Rochester	\$ 16,615,910
Western	\$ 6,722,096
Statewide	\$269,500,000

- b. \$25 million shall be distributed to non-major public hospitals having eligible for payments based upon each facility's proportion of uninsured losses as determined according to the methodology in the High Need Indigent Care Adjustment Pool of this Attachment.
- c. \$16 million shall continue to be proportionally distributed to non-teaching hospitals based on their proportion of uninsured losses as determined according to the methodology contained in the High Need Indigent Care Adjustment Pool of this Attachment.
- d. \$25 million shall be distributed to non-major public hospitals having Medicaid discharges of 40% or greater from data reported in each hospital's 2007 annual cost report; based on each hospital's decrease in Medicaid revenues resulting from the reductions in trend factors for 2008 and 2009 as contained in this Attachment and the inpatient and outpatient reimbursement methodology changes effective December 1, 2009.

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(I) High Need Indigent Care Adjustment Pool. Funds will be deposited as authorized and used for the purpose of making Medicaid disproportionate share payments within the limits established on an annualized basis pursuant to disproportionate share limitations, except as otherwise provided for in this section, for the period January 1, 2000 through December 31, 2010, in accordance with the following:

(1) From the funds in the pool each year:

(i) Each eligible rural hospital will receive a payment of \$140,000 on an annualized basis for the period January 1, 2000 through September 30, 2009. Effective on and after October 1, 2009, each eligible rural hospital will receive a payment of \$126,000 on an annualized basis, provided as a disproportionate share payment; provided, however, that if such payment pursuant to this clause exceeds a hospital's applicable disproportionate share limit, then the total amount in excess of such limit will be provided as a nondisproportionate share payment in the form of a grant directly from this pool;

(ii) Each such hospital will also receive an amount calculated by multiplying the facility's uncompensated care need by the appropriate percentage from the following scale based on hospital rankings developed in accordance with each eligible rural hospital's weight as defined by this section:

<u>Rank</u>	<u>Percentage Coverage of Uncompensated Care Need</u>
<u>1-9</u>	<u>60.0%</u>
<u>10-17</u>	<u>52.5%</u>
<u>18-25</u>	<u>45.0%</u>
<u>26-33</u>	<u>37.5%</u>
<u>34-41</u>	<u>30.0%</u>
<u>42-49</u>	<u>22.5%</u>
<u>50-57</u>	<u>15.0%</u>
<u>58+</u>	<u>7.5%</u>

(iii) "Eligible rural hospital", as used in paragraph (1), will mean a general hospital classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (Medicare) or under state regulations, or a general hospital with a service area which has an average population of less than 175 persons per square mile, or a general hospital which has a service area which has an average population of less than two hundred persons per square mile measured as population density by zip code.

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The average population of the service area is calculated by multiplying annual patient discharges by the population density per square mile of the county of origin or zip code as applicable for each patient discharge and dividing by total discharges. Annual patient discharges shall be determined using discharge data for the 1997 rate year, as reported to the commissioner by October 1, 1998. Population density shall be determined utilizing United States census bureau data for 1997.

- (iv) "Eligible rural hospital weight", as used in paragraph (1), shall mean the result of adding, for each eligible rural hospital:
- (a) The eligible rural hospital's targeted need, as defined in subparagraph (ii) of this section, minus the mean targeted need for all eligible rural hospitals, divided by the standard deviation of the targeted need of all eligible rural hospitals; and
  - (b) The mean number of beds of all eligible rural hospitals minus the number of beds for an individual hospital, divided by the standard deviation of the number of beds for all eligible rural hospitals.
- (2) From the funds in the pool each year, except as otherwise provided for in this section, \$36 million on an annualized basis for the periods January 1, 2000 through September 30, 2009, and for the periods on and after October 1, 2009, \$32.4 million on an annualized basis, of the funds not distributed in accordance with paragraph (1), shall be distributed in accordance with the formula set forth in paragraph (12) of the Medicaid disproportionate share payments section of this Attachment.
- (3) From the funds in the pool each year, any funds not distributed in accordance with paragraphs (1) or (2), shall be distributed in accordance with the formula set forth in subparagraph (d) of paragraph (10) of the Medicaid disproportionate share payments section.

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For annual periods beginning January 1, 2009 through December 31, 2010, disproportionate share hospital (DSH) payments shall be reduced to 90 percent of the amount otherwise payable. In addition, DSH payments to each general hospital will be distributed in accordance with the following:

- (a) \$13.93 million will be distributed to major government hospitals and will be allocated proportionally, based on each facility's relative uncompensated care need as determined in accordance with (c);
- (b) \$70.77 million will be distributed to general hospitals other than major government general hospitals and will be allocated proportionally, based on each facility's relative uncompensated care need as determined in accordance with (c);
- (c) each facility's relative uncompensated care need amount will be determined by multiplying inpatient units of services for all uninsured patients from the calendar year two years prior to the distribution year, excluding referred ambulatory units of services, by the applicable Medicaid inpatient rates in effect for such prior year, but not including prospective rate adjustments and rate add-ons, provided, however, that for distributions on and after January 1, 2010, the uncompensated amount for inpatient services shall utilize the inpatient rates in effect as of July 1 of the prior year; and;

by multiplying outpatient units of service for all uninsured patients from the calendar year two years prior to the distribution year, including emergency department services and ambulatory surgery services, but excluding referred ambulatory services units of service, by Medicaid outpatient rates that reflect the exclusive utilization of the ambulatory patient groups (APG) rate-setting methodology, however, for those services for which APG rates are not available the applicable Medicaid outpatient rate shall be the rate in effect for the calendar year two years prior to the distribution year.

For distributions on and after January 1, 2010, each facility's uncompensated need amount will be reduced by the sum of all payment amounts collected from such patients. The total uncompensated care need for each facility will then be adjusted by application of the existing nominal need scale.

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- (d) (i) Continuing annually for periods on and after January 1, 2009, no general hospital will receive DSH payment distributions that exceed the costs incurred by such hospital during the distribution period for providing inpatient and outpatient hospital services to Medicaid eligible patients or, uninsured patients. Such costs will be net of monies received from non-DSH related Medicaid payments and collections from uninsured patients.
- (ii) DSH payment reductions will first be made from the public general hospital indigent care adjustment payments pursuant to this Attachment, and then from payments from this section.
- (e) Distributions to voluntary sector general hospitals, excluding government general hospitals, made in accordance with the Medicaid Disproportionate Share Section, the Supplemental Indigent Care Distributions Section, and the High Need Indigent Care Adjustment Pool Section will be reduced proportionally by the final payment amounts paid to eligible voluntary sector general hospitals, excluding government general hospitals, made in accordance with the Additional Inpatient Hospitals Payments Section for the period commencing July 1, 2010 and annually thereafter.
- (f) In addition to reductions noted in paragraph (e), distributions to voluntary sector general hospitals, made in accordance with the Medicaid Disproportionate Share Section, the Supplemental Indigent Care Distributions Section, and the High Need Indigent Care Adjustment Pool Section will be reduced proportionally by \$69.4M for the period commencing July 1, 2010 through December 31, 2010 and by \$73.2M annually for rate periods commencing January 1, 2011 and thereafter excluding distributions made in accordance with subparagraphs (b), (c), and (d) of paragraph (3) of the Supplemental Indigent Care Distributions Section.

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**Hospital physician billing.**

1. With the exception of hospitals designated under the Medicare program as meeting the criteria set forth in §1861(b)(7) of the federal Social Security Act, for discharges occurring on and after February 1, 2010, hospitals may bill for physician services in accordance with the applicable Medicaid physician fee schedule in addition to billing the applicable DRG.

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Serious Adverse Events.

Effective October 1, 2008, the New York State Medicaid program shall deny reimbursement or reduce payment for the higher DRG arising from the following three serious adverse events, defined as avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients: foreign object left in patient after surgery, air embolism, and blood incompatibility. On and after November 1, 2009, hospitals will be required to bill all claims associated with one of the remaining ten (10) serious adverse events using the following procedures:

- a. For those cases where a serious adverse event occurs and the hospital elects to receive no payment for the admission (i.e., it is expected that Medicaid will deny the entire payment based on the type of event), the hospital will notify Medicaid of this case by submitting a claim using a new rate code 2590 (non-reimbursable with serious adverse events), along with the requisite billing information submitted with a claim.

Department of Health will identify claims billed with rate code 2590 and instruct the Island Peer Review Organization (IPRO), the New York State Medicaid review agent, to request the medical record for the admission and conduct a case review.

- b. For those cases where a serious adverse event occurs and the hospital anticipates at least partial payment for the admission, the hospital will follow a two-step process for billing the admission:
- i. The hospital will first submit their claim for the entire stay in the usual manner, using the appropriate rate code (i.e., rate code 2946 for DRG claims or the appropriate exempt unit per diem rate code such as 2852 for psychiatric care, etc.). That claim will be processed in the normal manner and the provider will receive full payment for the case.

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ii Once remittance for the initial claim is received, it will be necessary for the hospital to then submit an adjustment transaction to the original paid claim using one of the following two new rate codes associated with identification of claims with serious adverse events:

- 2591 (DRG with serious adverse events), or
- 2592 (Per Diem with serious adverse events)

The adjusted claim will then pend to the Department and will be forwarded to Island Peer Review Organization (IPRO) for further review. IPRO will review the medical record for the case to determine appropriate payment. Once IPRO has completed its review of the medical record, a preliminary notification indicating their findings will be issued. Hospitals will be required to respond to this preliminary finding within thirty days indicating whether it agrees or disagrees with the finding. If the provider disagrees with this preliminary finding, they may appeal by submitting additional rationale and supporting documentation to the IPRO. IPRO will then re-review the case taking into account the provider's rationale and supporting documentation. A final determination will be made at the conclusion of this process.

The thirteen serious adverse events are as follows:

- (1) Surgery performed on the wrong body part
- (2) Surgery performed on the wrong patient
- (3) Wrong surgical procedure on a patient
- (4) Foreign object inadvertently left in patient after surgery
- (5) Medication error
- (6) Air embolism
- (7) Blood incompatibility
- (8) Patient disability from electric shock

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**Graduate Medical Education - Medicaid Managed Care Reimbursement**

Teaching hospitals shall receive direct reimbursement from the State Medicaid Agency for graduate medical education (GME) costs associated with inpatient services rendered to patients enrolled in Medicaid managed care or Family Health Plus plans.

GME payments for DRG based services shall include the following:

- a. A direct graduate medical education (GME) payment per discharge calculated for each teaching hospital by dividing the facility's total reported acute care Medicaid direct GME costs by its total Medicaid acute care discharges in the applicable base period. Direct GME costs shall be those costs defined in the Definitions Section, derived from the same base period used to calculate the statewide base price for the applicable rate period, and trended forward to such rate period in accordance with applicable provisions of this Attachment.
- b. An indirect GME payment per discharge calculated for each teaching hospital by applying the actual applicable Service Intensity Weight for the discharge, Wage Equalization Factor Adjustment, and indirect teaching cost percentage described in this Attachment to the statewide base price. Each of these variables will be for the applicable rate year in which the discharge occurs.

GME payments for exempt unit or hospital services shall include a direct GME and an indirect GME component calculated as follows:

- a. A direct GME payment per discharge for each exempt unit or hospital by dividing the facility's applicable exempt unit or hospital Medicaid direct GME costs by the total Medicaid discharges for that exempt unit or hospital in the applicable base period. Direct GME costs shall be those costs defined in the Definitions Section, derived from the same base period used to calculate the average operating cost per diem for the applicable rate period, and trended forward to such rate period in accordance with applicable provisions of this Attachment.

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- b. An indirect GME payment per discharge for each exempt unit or hospital by applying the indirect teaching cost percentage calculated in accordance with this Attachment to the hospital's operating cost per diem calculated in accordance with the provisions of this Attachment excluding the costs of direct GME calculated in (a) above, converted to a per diem basis, and trended forward to the rate period in accordance with the provisions of this Attachment. Exempt unit or hospital GME rates per diem will be further adjusted by each applicable exempt unit or hospital's average length of stay based on the latest available data reported on the Institutional Cost Report for the reporting period two years prior to the rate year.

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**Disproportionate share limitations.**

1. Disproportionate share payment distributions made to general hospitals pursuant to this Attachment shall be limited in accordance with the provisions of this Section. The latest available annual cost report submitted by a hospital prior to the disproportionate share distribution period shall be used to determine eligibility pursuant to paragraph (2) and for projected limits pursuant to paragraph (5). Annual cost reports having an end date in the applicable annual disproportionate share distribution period, or for certain state-operated general hospitals, annual cost reports having an end date in the subsequent annual disproportionate share distribution period, shall be used to reconcile limits pursuant to paragraph (6).
2. General hospitals must meet the following conditions to receive disproportionate share distributions:
  - a. The hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for obstetric services under a state plan. This requirement doesn't apply to a hospital if their inpatients are predominantly under 18 years old or if the hospital does not offer nonemergency obstetric services to the general population as of December 22, 1987. If the hospital is a rural hospital, an obstetrician is any physician with staff privileges to perform nonemergency obstetric procedures.
  - b. The hospital must have a Medicaid inpatient utilization rate of at least one percent.
3. No general hospital shall receive in total from disproportionate share payment distributions an amount which exceeds the costs incurred during the periods described in paragraph (1) for furnishing inpatient and ambulatory hospital services to individuals who are eligible for medical assistance benefits pursuant to title XIX of the Federal Social Security Act (hereinafter referred to as "Medicaid cost") or to individuals who have no health insurance or other source of third party coverage (hereinafter referred to as "self-pay cost"), reduced by medical assistance payments made pursuant to title XIX of the Federal Social Security Act (hereinafter referred to as "Medicaid revenue"), other than disproportionate share payments, and payments by uninsured patients. For purposes of this Section, payments to a general hospital for services provided to indigent patients made by the State or a unit of local government within the State shall not be considered a source of third party payment.
4. In order to ensure the continued flow of disproportionate share payments to hospitals, the Commissioner shall make projections of each hospital's disproportionate share limitation based on the most current data available from the hospital's annual cost reports. The

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general hospitals whose annual cost reports have an end date within the subsequent annual period, each hospital's disproportionate share limitation shall be reconciled to the actual rate year data. This shall be referred to as the "reconciliation methodology".

5. Projection methodology. Each hospital's projected disproportionate share limitation for each rate year shall be the sum of its inpatient and outpatient Medicaid and uninsured gains/(losses) as calculated using reported base year data and statistics from the year two years immediately preceding the rate year and as used for projection methodology purposes for that prior year.
6. Reconciliation methodology. The Commissioner shall revise the projected limitation based on actual data reported to the Commissioner for such rate year in accordance with the following and in accordance with final regulations issued by the federal Department of Health and Human Services implementing 42 USC §1396r-4. The Commissioner shall revise the projected limitations for each hospital within eight months from the date required reports are submitted to the Department, except if such reports are determined to be unacceptable by the Department. For hospitals which have submitted unacceptable reports, the Commissioner shall revise the projected limitations within eight months from the date acceptable reports have been resubmitted to the Department.
  - a. Each hospital shall submit, by the same date the annual cost reports are required to be filed pursuant to the cost reporting requirements of this Attachment, a disproportionate share limitation schedule in a form and manner prescribed by the Commissioner within which the hospital shall calculate, in accordance with the instructions, its inpatient and outpatient Medicaid and self-pay gains/(losses) during the cost reporting year. The disproportionate share limitation schedule shall be accompanied by a certification by the hospital's independent public accountant which provides the Commissioner sufficient assurance as to the accuracy of the information contained in such schedule.
    - i. The final limit shall be calculated by excluding inpatient and outpatient Medicaid revenue impacts resulting from prospective adjustments to rates for periods prior to the implementation of the federal hospital specific disproportionate share payment limits from the inpatient and outpatient Medicaid and self-pay gains/(losses) reported on the disproportionate share payment limitation schedule.
  - b. Failure of a hospital to submit the information required by this Section in a form acceptable to the Commissioner shall result in the immediate withholding of all subsequent disproportionate share distributions. Such withholding shall continue until the hospital complies with the reporting requirements of this Subdivision.

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Government general hospital disproportionate share payments will be made to increase reimbursement to hospitals operated by the State of New York, the State University of New York or by county governments. To be eligible, hospitals must be operating at the time the payments are made. The payments are subject to the payment limits established in this Attachment of this plan.

1. Government general hospitals operated by the State of New York or the State University of New York shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007 and April 1, 2007 through March 31, 2009, and for the state fiscal years beginning April 1, 2009 through March 31, 2011, subject to the limits established pursuant to this Attachment. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002 after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 reconciled data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006.

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Such payments shall continue to be established for periods beginning on April 1, 2007, through March 31, 2008, based initially on 100% of reported 2000 reconciled data and further reconciled to 100% of actual reported data for 2007. For periods beginning April 1, 2008, through March 31, 2009, such payments shall be based initially on 100% of reported 2000 reconciled data and further reconciled to 100% of actual reported data for 2008. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For periods beginning April 1, 2009 through March 31, 2011, such payments shall be established based initially on reported 2007 reconciled data, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data for 2009, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

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2. Government general hospitals operated by a county, which does not include a city with a population of over one million, shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007, and April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, for the state fiscal years beginning April 1, 2009 through March 31, 2011, subject to the limits established pursuant to this Attachment. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002, after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 reconciled data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006.

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Such payments shall continue to be established for periods beginning on April 1, 2007, based initially on up to 100% of reported 2000 reconciled data as further reconciled to up to 100% of actual reported data for 2007, for state fiscal year beginning on April 1, 2008 through March 31, 2009, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2008. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For periods beginning April 1, 2009 through March 31, 2011, such payments shall be established based initially on reported 2007 reconciled data, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data for 2009, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

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Government general hospitals operated by a county, which does not include a city with a population of over one million, or beginning April 1, 1997, government general hospitals located in the county of Erie, shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007, April 1, 2007 through March 31, 2008 and April 1, 2008 through March 31, 2009, subject to the limits established in accordance with disproportionate share limitations. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002 after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 reconciled data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006. Such payments shall continue to be established for periods beginning on April 1, 2007, based initially on up to 100% of reported 2000 reconciled data as further reconciled to 100% of actual reported data for 2007 and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

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Government general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million, shall receive 120 million dollars in additional disproportionate share payments effective January 1, 1997 and 120 million dollars in additional disproportionate share payments during each state fiscal year commencing April 1, 1997 and thereafter until March 31, 2000, 120 million dollars in initial additional disproportionate share payments each state fiscal year commencing April 1, 2000 and thereafter until March 31, 2003, \$120 million during the state fiscal year April 1, 2005 through March 31, 2006, \$120 million during the state fiscal year beginning April 1, 2006 through March 31, 2007, \$120 million beginning April 1, 2007 through March 31, 2008, \$120 million during the state fiscal year beginning April 1, 2008 through March 31, 2009, \$420 million annually for the state fiscal years beginning April 1, 2009 through March 31, 2011, \$120 million annually for the state fiscal year beginning April 1, 2011, and annually thereafter. Such payments will be made to each qualified individual hospital based on the relative share of each such hospital's medical assistance and uninsured patient losses for 1997 after considering all other medical assistance payments to such government general hospitals based on 1994 reconciled data as further reconciled to actual reported 1997 reconciled data, for any payments made in 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 or 1998 reconciled data, for payments made during the state fiscal year beginning April 1, 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 or 1999 data, for payments made during the state fiscal year ending March 31, 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 or 2000 data, for payments made during the state fiscal year beginning April 1, 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 or 2001 data, for payments made during the state fiscal year beginning April 1, 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 or 2002 data, for payments made during the state fiscal year beginning April 1, 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 or 2003 data, for payments made for the state fiscal year beginning April 1, 2005 based initially on reported 2000 reconciled data, as further reconciled to actual reported 2005 or 2006 data, and for payments made for the state fiscal year beginning April 1, 2006, based initially on reported 2000 reconciled data, as further reconciled to actual reported 2006 or 2007 data.

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Such payments shall continue to be established for the state fiscal year beginning on April 1, 2007 based initially on reported 2000 reconciled data, as further reconciled to actual reported 2007 or 2008 data, for the state fiscal year beginning on April 1, 2008 through March 31, 2009, based initially on reported 2000 reconciled data, as further reconciled to actual reported 2008 or 2009 data. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For periods beginning April 1, 2009 through March 31, 2011, such payments shall be established based initially on reported 2007 reconciled data, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data for 2009, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

Beginning April 1, 2000 government general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million are authorized to receive additional disproportionate share payments as projected or reconciled pursuant to this Attachment governing disproportionate share payments to hospitals, based on the relative share of each such non-state operated government general hospital of projected or reconciled medical assistance and uninsured patient losses after payment of all other medical assistance, including disproportionate share payments to such government general hospitals. For the period April 1, 2000 through March 31, 2001, an additional payment of \$103 million is authorized. Effective April 1, 2001 through March 31, 2002, additional payments of \$113 million are authorized. For the state fiscal years beginning April 1, 2002 and ending March 31, 2009, and each state fiscal year thereafter, additional annual payments of \$210 million are authorized. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For state fiscal years beginning April 1, 2003 and ending March 31, 2005, the Department of Health is authorized to pay government general hospitals, operated by the State of New York or by the State University of New York additional payments for inpatient hospital services as medical assistance payments for patients eligible for federal financial participation under Title XIX of the federal social security act pursuant to the federal laws and regulations governing disproportionate share payments to hospitals 175 percent of each such government general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such government general hospital, based initially on reported 2000 reconciled data. Such payments for the periods ending March 31, 2004 and March 31, 2005, shall be further reconciled to actual reported 2003 and 2004 data respectively, provided, however, that such payments for all eligible hospitals shall be reduced to the extent such payments would result in the exceeding of the State's disproportionate share allotment limit, as determined in accordance with federal statute and regulations, provided, however, that such reduction shall be based on each such hospital's proportionate share of the sum of all such payments that would be made without regard to such allotment limit. Such payments may be added to rates of payment or made as aggregate payments to an eligible government general hospital.

TN #09-34 \_\_\_\_\_ Approval Date JAN 20 2010  
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**Reimbursable Assessment on Hospital Inpatient Services**

Effective January 1, 2006, and thereafter, an assessment on net patient services revenue for hospital inpatient services rendered to Medicaid beneficiaries shall be considered an allowable cost and reimbursed through an adjustment to Medicaid services rates of payment.

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New York  
160

Attachment 4.19-A  
(10/09)

**Government general hospital indigent care adjustment.**

For rate periods commencing January 1, 1997 and thereafter, each eligible government general hospital shall receive an annual amount equal to the amount allocated to such government general hospitals as determined pursuant to this Attachment for the period January 1, 1996 through December 31, 1996. The adjustment may be made to rates of payment or as aggregate payments to an eligible government general hospital and is contingent upon all federal approvals necessary by federal law and rules for federal financial participation for medical assistance under Title XIX of the federal Social Security Act based upon the adjustment provided herein as a component of such payments being granted.

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New York  
161

Attachment 4.19-A  
(04/09)

Effective for the state fiscal years beginning April 1, 2001 and ending March 31, 2010, specialty hospital adjustments for services provided on or after April 1, 2001, are authorized to government general hospitals, other than those operated by the State of New York or the State University of New York, receiving reimbursement for all inpatient services under Title XIX of the federal Social Security Act (Medicaid) pursuant to this Attachment of this State Plan and located in a city with a population of over one million, of up to \$286 million annually, as medical assistance payments. For the period beginning April 1, 2008 through March 31, 2009, and April 1, 2009 through March 31, 2010, such payments shall total \$232.1 million and \$380,935,268 million, respectively. Such payments, when aggregated with other medical assistance payments, shall not exceed 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state government owned or operated government general hospitals for the respective periods and shall be based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

Effective for the period September 1, 2001 through March 31, 2002 and state fiscal years beginning April 1, 2002 and ending March 31, 2008, additional specialty hospital adjustments for services provided on or after September 1, 2001 are authorized to government general hospitals, other than those operated by the State of New York or the State University of New York, receiving reimbursement for all inpatient services under Title XIX of the federal social security act (Medicaid) pursuant to this Attachment of this State Plan and located in a city with a population of over one million, of up to \$463 million for the period September 1, 2001 through March 31, 2002 and \$794 million annually for state fiscal years beginning April 1, 2002 and ending March 31, 2008, as medical assistance payments based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

TN #09-16 \_\_\_\_\_

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New York  
161(1)

Attachment 4.19-A  
(04/10)

Effective for the period July 1, 2010 through March 31, 2011, additional inpatient hospital payments are authorized to voluntary sector hospitals, excluding government general hospitals, for inpatient hospital services after all other medical assistance payments, of \$235.5M for the period July 1, 2010 through March 31, 2011 and \$314M for the period April 1, 2011 through March 31, 2012 subject to the requirements of 42 CFR 447.272 (upper payment limit). Such payments may be added to rates of payment or made as aggregate payments to eligible voluntary sector owned or operated general hospitals, excluding government general hospitals.

Eligibility to receive such additional payments will be based on data from the period two years prior to the rate year, as reported on the Institutional Cost Report (ICR) submitted to the Department as of October 1 of the prior rate year.

(a) Thirty percent of such payments will be allocated to safety net hospitals based on each eligible hospital's proportionate share of all eligible safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;

(i) Safety net hospitals are defined as non-government owned or operated hospitals which provide emergency room services having either: a Medicaid share of total inpatient hospital discharges of at least 35%, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least 30%, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services.

(b) Seventy percent of such payments will be allocated to eligible general hospitals, which provide emergency room services, based on each such hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;

(c) No eligible general hospital's annual payment amount will exceed the lower of the sum of the annual amounts due that hospital in accordance with the Medicaid Disproportionate Share Section, the Supplemental Indigent Care Distributions Section, and the High Need Indigent Care Adjustment Pool Section of this Attachment, or the hospital's facility specific projected disproportionate share hospital payment ceiling

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New York  
161(1)(a)

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(04/10)

established pursuant to federal law. Payment amounts to eligible hospitals pursuant to paragraphs (a) and (b) of this section in excess of the lower of such sum or payment ceiling will be reallocated to eligible hospitals that do not have excess payment amounts. Such reallocations will be proportional to each such hospital's aggregate payment amount pursuant to paragraphs (a) and (b) of this section to the total of all payment amounts for such eligible hospitals; and

(d) These payments will be included in Medicaid revenues for the purpose of computing each general hospital's disproportionate share limitations.

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New York  
161(a)

Attachment 4.19-A  
(10/09)

**Medicaid disproportionate share payments.**

1. For the rate periods commencing January 1, 1991 and thereafter, Medicaid disproportionate share payments shall be made to hospitals to reimburse a portion or all of the costs associated with serving those patients unable or unwilling to pay for services rendered.
2. For rate periods commencing January 1, 1997 and thereafter, uncompensated care need shall mean losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient services. The cost of services provided as an employment benefit or as a courtesy shall not be included.
3. For rate periods commencing January 1, 1997 and thereafter, targeted need shall be defined as the relationship of uncompensated care need to reported costs expressed as a percentage. Reported costs shall mean costs allocated as prescribed by the Commissioner to government general hospital inpatient services. Targeted need shall be determined based on base year data and statistics for the calendar year two years prior to the distribution period.
4. Nominal payment amount shall be defined as the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to the scale specified in this section.
5. For rate periods commencing January 1, 1997 and thereafter, targeted need share shall mean the relationship of each general hospital's nominal payment amount of uncompensated care need determined in accordance with the scale specified in this section to the nominal payment amounts of uncompensated care need for all eligible general hospitals applied to funds available for distribution pursuant to this section.
6. Major government general hospitals shall mean all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospital Corporation and all other government general hospitals having annual inpatient operating costs in excess of \$25 million.
7. Voluntary sector hospitals shall mean all voluntary non-profit, private proprietary and government general hospitals other than major government general hospitals.
8. For rate periods commencing January 1, 1997 and thereafter, uninsured care shall be defined as losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient services, which are not eligible for payment in whole or in part by a governmental agency, insurer or other third-party payor on behalf of a patient, including payment made

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161(b)

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directly to the government general hospital and indemnity or similar payments made to the person who is a payor of hospital services. The costs of services denied reimbursement, other than emergency room services, for lack of medical necessity or lack of compliance with prior authorization requirements, or provided as an employment benefit, or as a courtesy shall not be included.

9. In order to be eligible for distributions, a general hospital's targeted need must exceed one-half of one percent.
10. For rate years commencing January 1, 1991 and prior to January 1, 1997, each eligible major government general hospital shall receive a portion of its bad debt and charity care need equal to 110 percent of the result of the application of the percentage of statewide inpatient reimbursable costs excluding costs related to services provided to beneficiaries of Medicare, developed on the basis of 1985 financial and statistical reports, to the statewide resources for the rate year.
  - a. Statewide resources shall mean the sum of the result of multiplying a statewide average 5.48% by each general hospital's (including major government general hospitals and all other hospitals) rate year reimbursable inpatient costs used in the initial promulgation of rates, adjusted of case mix and volume changes, excluding inpatient costs related to services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare), and without consideration of inpatient uncollectible amounts, and including income from invested funds.
11. For rate periods commencing January 1, 1997 through December 31, 2010, each eligible major government general hospital shall receive an amount equal to the amount allocated to such major government general hospital for the period January 1, 1996 through December 31, 1996.
12. For rate periods commencing January 1, 1997 and thereafter, the balance of unallocated funds after the Medicaid disproportionate share payments are made in accordance with paragraph (10) of this section and funds are reserved for distribution as high need adjustments in accordance with paragraph (12) of this section and shall be distributed to eligible hospitals, excluding major government general hospitals, on the basis of targeted need share.
  - a. Need calculations shall be based on need data for the year two years prior to the rate year.

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161(b)(i)

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- b. For the rate periods commencing January 1, 1991 and prior to January 1, 1997, the scale specified in this section, and for rate periods commencing January 1, 1997 and thereafter, the scale specified in subparagraph (d) of this section shall be utilized to calculate individual hospital's nominal payment amounts on the basis of the percentage relationship between their need for the year two years prior to the rate year and their patient service revenues for the year two years prior to the rate year.
- c. The scale utilized for development of each hospital's nominal payment amount shall be as follows:

<u>Targeted Need Percentage</u>	<u>Percentage of Reimbursement Attributable to the Portion of Targeted Need</u>
<u>0 - 1%</u>	<u>35%</u>
<u>1+ - 2%</u>	<u>50%</u>
<u>2+ - 3%</u>	<u>65%</u>
<u>3+ - 4%</u>	<u>85%</u>
<u>4+ - 5%</u>	<u>90%</u>
<u>5+%</u>	<u>95%</u>

- d. The scale utilized for development of each eligible government general hospital's nominal payment amount shall be as follows:

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<u>Targeted Need Percentage</u>	<u>Percentage of Reimbursement Attributable to the Portion of Targeted Need</u>
<u>0 - 0.5%</u>	<u>60%</u>
<u>0.5+% - 2%</u>	<u>65%</u>
<u>2+ - 3%</u>	<u>70%</u>
<u>3+ - 4%</u>	<u>75%</u>
<u>4+ - 5%</u>	<u>80%</u>
<u>5+ - 6%</u>	<u>85%</u>
<u>6+ - 7%</u>	<u>90%</u>
<u>7+ - 8%</u>	<u>95%</u>
<u>8+%</u>	<u>100%</u>

12. For rate periods commencing January 1, 1997 through December 31, 2010, \$36 million shall be distributed as high need adjustments to general hospitals, excluding major government general hospitals, with nominal payment amount in excess of 4 percent of reported costs as follows: each general hospital's share shall be based on such hospital's aggregate share of nominal payment amount above 4 percent of reported costs compared to the total aggregate nominal payment amount above 4 percent of reported costs of all eligible hospitals.

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**Additional disproportionate share payments.**

Beginning April 10, 1997 and for annual periods beginning April 1<sup>st</sup> thereafter, additional disproportionate share payments shall be paid to voluntary non-profit general hospitals. Such payments shall not exceed each such general hospital's cost of providing services to uninsured and Medicaid patients after taking into consideration all other medical assistance payments received, including disproportionate share payments made to such general hospitals and payments from and on behalf of such uninsured patients and shall also not exceed the amount of state aid for which the hospital or its successor would have been eligible pursuant to the Funding for Substance Abuse Services and the Local Unified Services Sections of the Mental Hygiene Law (as described below) for fiscal year 1996-97, the Base Year. Such additional disproportionate share payments will be calculated by aggregating net approved operating costs for such mental health and/or alcoholism or substance abuse programs in each hospital. Net operating costs are defined as operating costs offset by revenues, other income, federal aid and fees. The payments may be made as quarterly aggregate payments to an eligible hospital.

Payments beginning April 1, 1998 and thereafter will be related to the hospital's willingness to continue to provide services previously funded by state aid grants. The Commissioners of the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS), in consultation with county directors of community services, will annually designate to the Department of Health those general hospitals eligible for the additional disproportionate share payment, and the amount thereof. If a hospital does not continue to provide substantially the same level of program and/or services as in the Base Year, the local governmental unit can recommend to the Commissioner of OMH and/or the Commissioner of OASAS that the provider not be designated to receive disproportionate share payments for mental health and/or substance abuse and alcoholism services in the future. In addition, if a hospital reduces its deficit from that of the Base Year, either as a result of increased program revenues, or as a result of program or service cutbacks, or as a result of lower costs, the local governmental unit can recommend to OMH and/or OASAS that the additional disproportionate share payment be reduced commensurate with the decrease in the deficit.

Services funded under the Local and Unified Services Section of the Mental Hygiene Law include mental health services. Alcoholism services funded under the Local and Unified Services section of the Mental Hygiene Law include health and alcoholism treatment services. Substance abuse services funded under Funding for Substance Abuse Services Section of the Mental Hygiene Law include health and substance abuse services.

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# Attachment A

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Pages 103, 104, 104(a), 105, 106, 106(a), 107, 108, 108(a), 109, 109(a), 110, 110(a), 111, 111(a), 112, 112(a), 112(b), 112(c), 112(d), 112(e), 112(f), 112(f)(1), 112(f)(2), 112(g), 112(h), 113, 113(a), 113(b), 113(b)(1), 113(b)(2), 113(b)(2)(i), 113(b)(2)(ii), 113(b)(3), 113(c), 114, 114(a), 114(b), 115, 116, 117, 117(a), 117(a)(1), 117(b), 117(c), 117(d), 117(e), 118, 118(a), 119, 120, 120(a), 121, 121(a), 122, 123, 124, 125, 126, 127, 127(a), 128, 129, 130, 131, 131(a), 131(b), 131(c), 131(c)(1), 131(d), 131(e), 131(f), 131(g), 131(h), 132, 132(a), 133, 134, 134(a), 135, 136, 136(a), 136(b), 136(b)(1), 136(b)(2), 136(b)(3), 136(c), 136(c)(1), 136(d), 136(e), 137, 137(a), 138, 139, 139(a), 140, 141, 141(a), 142, 142(a), 143, 143(a), 144, 144(a), 144(b), 144(b)(1), 144(c), 144(d), 144(e), 145, 145(a), 145(b), 145(c), 145(d), 146, 146(a), 146(a)(1), 147, 148, 148(a), 148(b), 149, 149(a), 149(a)(i), 149(a)(ii), 149(a)(1), 149(a)(2), 149(b), 149(c), 149(d), 149(e), 150, 150(a), 151, 151(a), 152, 152(a), 153, 153(a), 153(b), 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 165(a), 165(b), 165(c), 165(d), 165(e), 165(f), 165(g), 165(h), 165(i), 165(j), 165(k), 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 175(a), 175(b), 175(c), 175(d), 175(d)(1), 175(d)(2), 175(d)(3), 175(d)(4), 175(d)(5), 175(d)(6), 175(d)(7), 175(d)(8), 175(d)(9), 175(d)(10), 175(d)(11), 175(d)(12), 175(d)(13), 175(d)(14), 175(d)(15), 175(d)(16), 175(d)(17), 175(d)(18), 175(d)(19), 175(d)(20), 175(d)(21), 175(d)(22), 175(d)(23), 175(d)(24), 175(d)(25), 175(D)(26), 175(D)(27), 175(D)(28), 175(D)(29), 175(D)(30), 175(D)(31), 175(D)(32), 175(D)(33), 175(D)(34), 175(D)(35), 175(D)(36), 175(D)(37), 175(D)(38), 175(D)(39), 175(D)(40), 175(D)(41), 175(D)(42), 175(D)(43), 175(D)(44), 175(D)(45), 175(D)(46), 175(D)(47), 175(D)(48), 175(D)(49), 175(D)(50), 175(e), 176, 176(a), 176(b), 176(c), 176(c)(1), 176(d), 176(e), 176(f), 176(g), 176(h), 176(i), 176(j), 176(k), 176(l), 176(m), 176(n), 176(o), 176(p), 176(q), 176(r), 176(s), 176(t), 176(u), 176(v), 176(w), 176(x), 176(x)(1), 176(x)(2), 176(x)(3), 176(x)(4), 176(x)(5), 176(x)(6), 176(x)(7), 176(x)(8), 176(x)(9), 176(x)(10), 176(x)(11), 176(x)(12), 176(x)(13), 176(x)(14), 176(x)(15), 176(x)(16), 176(x)(17), 176(x)(18), 176(x)(19), 176(x)(20), 176(x)(21), 176(x)(22), 176(x)(23), 176(x)(24), 176(x)(25), 177, 177(a), 178, 179, 179(a), 180, 180(a), 180(b), 180(c), 180(d), 180(e), 180(f), 180(g), 180(g)(1), 180(h), 180(i), 181, 181(a), 181(b), 182, 182(a), 183, 183(a), 184, 184(a), 185, 185(a), 185(b), 186, 187, 188, 188(a), 188(a)(1), 188(b), 188(b)(A), 188(b)(B), 188(b)(C), 188(b)(D), 188(b)(E), 188(b)(1), 188(b)(2), 188(b)(3), 188(b)(4), 189, 189(a), 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 210(a), 210(b), 211, 211(a), 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 222(a), 223, 224, 225, 226, 226(a), 226(b), 227, 228, 229, 230, 230(a), 230(b), 230(c), 230(d), 231, 231(a), 232, 232(a), 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 246(a), 246(b), 246(c), 246(d), 246(e), 246(f), 247, 248, 248(a), 248(a)(1), 248(b), 248(b)(1), 249(a), 249, 249(a)(1), 249(a)(2), 249(a)(3), 249(b), 249(c), 249(d), 249(d)(1), 249(e), 250, 251, 252, 253, 253(a)

Note: The State does not have a Page 233

STATE <u>NY</u>	A
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Attachment B

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APPENDIX I

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New York  
Proxies and Sources  
Hospitals

Appendix I  
Attachment 4.19A  
Part I Page 1

ITEM	PROXY
<b>Labor</b>	
<u>Executive, Administrative and Managerial Personnel</u>	<u>ECI-Civilian-Compensation-Executive, Administrative and Managerial 1/</u>
<u>Professional and Technical Personnel</u>	<u>ECI-Civilian-Compensation-Professional and Technical 1/</u>
<u>All Other Personnel</u>	<ol style="list-style-type: none"> <li>1. <u>ECI-Civilian-Compensation-Service Occupation 41.1% 1/</u></li> <li>2. <u>ECI-Civilian-Compensation-Clerical 45.0% 1/</u></li> <li>3. <u>ECI-Civilian-Compensation-Blue Collar 8.9% 1/</u></li> <li>4. <u>ECI-Compensation-Private Industry-Workers-Union-Service Producing Industries 5.0% 1/</u></li> </ol>
<u>Regional Adjustment Factor</u>	<u>Average hourly earnings industry composite-New York and U.S. - 50% CPI-U-New York City Area, Buffalo Area, Northeast Size b, Northeast Size C, U.S. - 50%</u>
<b>Administrative and General</b>	
<u>Telephone</u>	<u>Telephone rate index</u>
<u>Postage</u>	<u>Consumer Price Index (CPI-W)</u>
<u>Insurance - malpractice and umbrella</u>	<u>Malpractice survey</u>
<u>Insurance - General Liability and property</u>	<u>General Liability insurance rates</u>
<u>Insurance Automobile</u>	<u>Automobile insurance (ECI)</u>
<u>Insurance - Other</u>	<u>Insurance Composite</u>

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New York  
Proxies and Sources  
Hospitals

Appendix I  
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Part I  
Page 2

ITEM	PROXY
<u>Legal Fees</u>	<u>ECI-Compensation-Private Industry Workers-Professional Specialty &amp; Technical 1/</u>
<u>Accounting Fees</u>	<u>ECI-Compensation-Private Industry Workers -Executive, Administrative and Managerial 1/</u>
<u>Office Supplies</u>	<ol style="list-style-type: none"> <li>1. <u>Office Supplies &amp; Accessories (PPI) - 40%</u></li> <li>2. <u>Office Machines NEC - 12.5% (PPI)</u></li> <li>3. <u>Writing and Printing Papers - 20% (PPI)</u></li> <li>4. <u>Pens, Pencils and Marking Devices - 12.5% (PPI)</u></li> <li>5. <u>Classified Advertising - 7.5% (PPI)</u></li> <li>6. <u>Periodicals, Circulation - 7.5% (PPI)</u></li> </ol>
<u>Management Consulting Fees</u>	<u>Average hourly earnings - Management and Public Relation Services 2/</u> <ol style="list-style-type: none"> <li>a. <u>ECI Private Industry Workers - Compensation - Executive, Administrative and Managerial 3/</u></li> <li>b. <u>ECI - Private Industry Workers - Wages and Salaries - Executive, Administrative and Managerial 3/</u></li> </ol>
<u>Data Processing</u>	<u>Average Hourly Earnings - Computer and Data Processing Services 2/</u> <ol style="list-style-type: none"> <li>a. <u>ECI-Private Industry Workers-Compensation-Professional Specialty and Technical 3/</u></li> <li>b. <u>ECI-Private Industry Workers-Wages and Salaries-Professional Specialty and Technical 3/</u></li> </ol>
<u>Interest Expense - Working Capital</u>	<u>Predominant prime time</u>
<u>Real Estate Taxes</u>	<ol style="list-style-type: none"> <li>1. <u>NYC tax rates</u></li> <li>2. <u>Upstate overall tax rates</u></li> </ol>
<u>Dietary</u>	<ol style="list-style-type: none"> <li>1. <u>All Foods (PPI) - 40%</u></li> <li>2a. <u>Food at Home, U.S. City average (CPI) or</u></li> <li>2b. <u>Food at Home, NY-NENJ (CPI) - 40%</u></li> <li>3. <u>Cups and Liquid - Tight Containers (PPI) - 3%</u></li> <li>4. <u>Tableware, Serving Pieces, and Nonelectric Kitchenware (CPI) - 7%</u></li> <li>5a. <u>Food Away From Home, (CPI) U.S. City average or</u></li> <li>5b. <u>Food Away From Home, NY-NENJ (CPI) - 10%</u></li> </ol>

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New York  
Proxies and Sources  
Hospitals

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ITEM	PROXY
<u>Operation and Maintenance of Plant</u>	
<u>Maintenance &amp; Repairs</u>	<u>Maintenance &amp; Repairs (CPI)</u>
● <u>#2 Fuel oil</u>	<u>Price, Tank Car Reseller, NYC &amp; Albany</u>
● <u>#6 Fuel oil</u>	<u>Price, Tank Car Reseller, NYC &amp; Albany</u>
● <u>Natural Gas</u>	<u>NYSDPS data for Brookly Union, Central Hudson, Columbia Gas, Con-Ed, L.I. Lighting, National Fuel Dist., Niagara Mohawk, NYS Electric &amp; Gas, Orange &amp; Rockland, Rochester Gas &amp; Electric</u>
● <u>Purchased Steam</u>	<u>NYSDOH Price Index for Con-Ed purchased steam</u>
● <u>Electric Power</u>	<u>NYSDPS price index for Con-Ed, L.I. Lighting, Orange &amp; Rockland, Central Hudson, NYS Electric &amp; Gas, Niagara Mohawk, Rochester Gas &amp; Electric</u>
● <u>Water and Sewer</u>	<u>Water and Sewerage Maintenance (CPI)</u>
● <u>Waste Disposal</u>	<u>Refuse Collection (CPI)</u>
● <u>Laundry and Linen</u>	<u>Laundry and Dry Cleaning Other than Coin Operator (CPI)</u>
● <u>Housekeeping</u>	<ol style="list-style-type: none"> <li>1. <u>Soap and Synthetic Detergents - 40% (PPI)</u></li> <li>2. <u>Unsupported Plastic Film and Sheeting - 30% (PPI)</u></li> <li>3. <u>Sanitary Papers and Health Products - 30% (PPI)</u></li> </ol>
● <u>Security</u>	<u>ECI-Private Industry Worker-Compensation - Service Occupation 1/</u>

TN 98-06

Date APR 6 2000  
JAN 1 1998

Supersedes TN 95-06 Date \_\_\_\_\_

TN 98-06

Effective Date APR 6 2000

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Supersedes TN 95-06 Effective Date JAN 1 1998

ITEM	PROXY
Professional Services	
• Maintenance & Repairs	Equipment/ECI-Private Industry Workers-Compensation-Service Industry 1/
• Drugs	<ol style="list-style-type: none"> <li>1. Preparations, Ethical (Prescription) (PPI) - 72.0%</li> <li>2. Preparation, Prop. (Over the Counter) (PPI) - 5.0%</li> <li>3. Prescription Drugs (CPI) - 23.0%</li> </ol>
• Medical Supplies	<ol style="list-style-type: none"> <li>1. Medical Instruments and Apparatus - 45% (PPI)</li> <li>2. Surgical Appliances and Supplies - 55% (PPI)</li> </ol>
• Non-Medical Supplies	<ol style="list-style-type: none"> <li>1. Office Supplies &amp; Accessories (PPI) - 40%</li> <li>2. Office Machines NEC - 12.5% (PPI)</li> <li>3. Writing and Printing Papers - 20% (PPI)</li> <li>4. Pens, Pencils and Marking Devices - 12.5% (PPI)</li> <li>5. Classified Advertising - 7.5% (PPI)</li> <li>6. Periodicals, Circulation - 7.5% (PPI)</li> </ol>
• Physicians Fees	Physicians' Services (CPI) 4/
• Other Medical Professional	ECI-Compensation-Civilian-Professional Specialty and Technical 1/
• X-Ray Film	Change in manufacturer's list prices
• Reagents	Reagents (PPI)
• Blood	NYSDOH price index of 5 blood products
• Travel and Conferences	Private Transportation (CPI)
• Employment Agency Fees- Nursing	ECI-Private Industry Workers-Compensation-Professional Specialty and Technical 1/
• Employment Fees	ECI - Civilian - Compensation - Clerical 1/

1/Includes Regional Adjustment Factor  
2/Includes Regional Adjustment Factor and Compensation Factor  
3/Excludes Regional Adjustment Factor  
4/Includes Regional Adjustment Factor and Excludes Compensation Factor

APPENDIX II

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Supersedes TN New Effective Date NOV 13 1999

PHASE I HOSPITALS

Albany Medical Center  
Auburn Memorial  
Beth Israel Medical Center  
Bronx-Lebanon  
City Hospital at Elmhurst  
Community Hospital Western Suffolk  
Cortland Memorial  
Ellis Hospital  
Essex County Medical Center  
Long Beach Memorial  
Maimonides  
Mercy Hospital, Rockville  
Metropolitan Hospital  
Nassau County Medical Center  
Niagara Falls Memorial  
St. Joseph's, Yonkers  
St. Luke's Roosevelt  
St. Vincent's, NYC  
St. Vincent's, Richmond  
Southside Hospital  
State University-Upstate  
Strong Memorial  
Summit Park  
SUNY Stony Brook  
United Health Services  
Westchester County MC  
Women's Christian  
Woodhull

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PHASE II HOSPITALS

Bayley Seton Hospital  
Buffalo General Hospital  
Cabrin Medical Center  
Central General Hospital  
Champlain Valley Hospital  
Clifton Springs Hospital  
Coney Island Hospital  
Eastern Long Island Hospital  
Franklin General Hospital  
Genesee Hospital  
Glens Falls Hospital  
Good Samaritan Hospital of Suffern  
Harlem Hospital  
Mary Imogene Bassett  
Montefiore Medical Center  
North Central Bronx Hospital  
Presbyterian Hospital  
Queens Hospital  
Samaritan Hospital  
Saratoga Hospital  
St. Barnabas Hospital  
St. Francis Hospital  
St. James Mercy Hospital  
St. Mary's Hospital  
St. Vincent's Hospital-Westchester

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METHODS AND STANDARDS OF SETTING PAYMENT RATES FOR  
INPATIENT SERVICES PROVIDED BY HOSPITALS  
OPERATED BY THE NEW YORK STATE OFFICE OF MENTAL HEALTH

In accordance with the Mental Hygiene Law the Office of Mental Health (OMH) establishes Medicaid inpatient rates of reimbursement, subject to the approval of the Director of the State Division of the Budget, for the psychiatric hospitals it operates. Statewide average payment rates shall be established for each of the rate categories outlined below under section I. The rates shall be established on a prospective basis in advance of the payment year.

I. [GENERAL]RATE CATEGORIES

[A separate rate is established for each of the following categories:]

[1] A. Adult Services

This rate category includes all inpatient units located at OMH Medicare and Medicaid certified Psychiatric Centers with the exception of Forensic Psychiatric Centers and discrete specialized units for children and youth for which separate rate categories are established.

[2] B. Children's Services

This rate category applies to those separate and distinct Children's Units operated by the OMH. The Children's Units provide psychiatric care and treatment exclusively to children and/or adolescents. These Children's Units are located both within OMH Medicare and Medicaid certified psychiatric centers as well as in separately accredited Children's Psychiatric Centers certified only under the Medicaid Program.

[3] C. Forensic Psychiatric Centers

This rate category applies to those separate and distinct inpatient facilities that provide services to clients involved with the criminal justice system. These facilities provide a highly secure treatment environment for patients who are too dangerous to be treated in State civil psychiatric centers.

[Medicaid inpatient rates for each category are established prospectively on a statewide basis by averaging together each of the per diem rate components outlined below for all Medicaid certified facilities.]

II. BASE YEAR [OPERATING] PER DIEM

[The operating per diem of the inpatient Medicaid rates is developed by averaging together the following:] Allowable base year costs shall be determined as follows:

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Effective Date JUL - 1 2005

A. [For] Medicare Certified Psychiatric Centers (including Forensic Psychiatric Centers)

[The Medicare (Title XVIII)per diem payment rates resulting from the final settlement of OMH's Medicare cost reports covering the fiscal year ended March 31, 1998.]

1. Inpatient routine and ancillary per diem cost shall be obtained from the Medicare final settled cost reports for the fiscal year ended March 31, 2002. Medicare final settlements are issued by OMH's Medicare Fiscal Intermediary following their review and audit of the Medicare cost reports submitted by OMH for each of the Medicare participating providers it operates. [For purposes of Medicare reimbursement OMH Psychiatric Hospitals are treated as PPS exempt providers with payment rates developed in accordance with 42 CFR section 413.40.]

2. Allowable inpatient cost shall be inclusive of capital cost and shall be determined without consideration of the Medicare facility-specific target rate limits or the Medicare national 75<sup>th</sup> percentile caps under 42 CFR § 413.40.

3. Allowable cost shall include the professional services of hospital-based physicians. The allowable cost of physicians services shall be determined subject to the Medicare reasonable compensation equivalent (RCE) limits under 42 CFR § 415.70. For purposes of applying this limitation the most recently issued RCE limits shall be trended to the applicable rate year based upon the increase in the Consumer Price Index for All Urban Consumers (CPI-U).

B. [For] Children's Psychiatric Centers

Since the Children's Psychiatric Centers are not Medicare participating providers Medicare final settlements are not processed for these providers. As such, the [base inpatient per diem] allowable inpatient cost for these facilities shall be determined [based on their average inpatient cost per day for the base year. The base year to be utilized shall be the same fiscal year as that used for the Medicare participating psychiatric centers as outlined under paragraph II.A. above.

The inpatient cost per day for the Children's Psychiatric Centers shall be determined] in accordance with the cost reporting and cost-finding methods developed by the Hospital industry as adopted by the Medicare (Title XVIII) and Medicaid (Title XIX) Programs. In determining those items of cost that shall be determined to be allowable, Medicaid (Title XIX) laws, rules and regulations shall be applied in accordance with paragraph III.A. below.

JUN - 1 2006

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[C. Exclusion of Capital Cost

In developing the statewide average base year operating per diem for each rate category, capital costs shall be eliminated from the amounts included in the per diems described above under paragraphs II.A. and II.B. For purposes of this section capital costs shall be determined in accordance with the Medicare (Title XVIII) principles of reimbursement and accordingly will include depreciation on capital assets and interest expense on indebtedness incurred to construct or purchase capital assets.]

III. ADJUSTMENTS FOR MEDICAID PURPOSES

In determining the allowable base year operating per diem outlined under paragraph II above adjustments shall be made to reflect the following:

A. Differences in Medicare vs. Medicaid Covered Services

The final Medicare inpatient payment rates as referenced under paragraph II.A. above shall be adjusted to exclude the costs of any services included therein which have been determined to be non-reimbursable under the Medicaid Program [(i.e. patient education programs).] In addition the costs associated with any services covered under New York State's Medicaid Program but not reimbursable under the Medicare program (e.g. dental services) shall be added [to the final Medicare payment rates] to determine Medicaid allowable costs.

[B. Other Allowable Costs

The base year per diem operating component developed in accordance with paragraph II above shall be adjusted to include other costs allowed under the Medicare principles of reimbursement but not claimed in the individual facility Medicare cost reports for the base year as referenced under paragraph II.A. above. This adjustment shall include costs related to services which have historically been included in the calculation of the OMH statewide inpatient Medicaid payment rates and found to be reimbursable by the Health Care Financing Administration.]

IV. TREND FACTOR

A trend factor shall be utilized in order to project the base year operating per diems as developed under paragraph II above to the applicable rate year. This trend factor will be developed by compounding the applicable increases in the Medicare RPL (rehabilitation, psychiatric and long-term care) market basket index[es for each year] between the base year and the rate year. In calculating the current year's rates the OMH shall utilize estimates in instances where the actual increase in the RPL market basket has

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not yet been determined for any particular years between the base year and the rate year. Once the actual increases in the RPL have been determined the OMH will include an adjustment in the subsequent year's rate to compensate for any difference between the estimated and actual increases in the RPL market basket. For purposes of this section the Medicare RPL market basket index is that published by the Federal [Health Care Financing Administration (HCFA)] Centers for Medicare and Medicaid Services (CMS) [pursuant to 42 CFR section 413.40 for hospitals and units of hospitals which are exempt from the Medicare Inpatient Prospective Payment System (PPS)] for determining Medicare reimbursement to psychiatric hospitals under the inpatient psychiatric facilities prospective payment system (IPFs PPS).

V. ACCREDITATION ADJUSTMENT

A per diem adjustment shall be incorporated in the inpatient Medicaid rates for OMH facilities to account for additional costs incurred subsequent to the base year used to develop the operating per diem pursuant to paragraph II above in order to meet minimum Medicaid and Medicare facility accreditation requirements. In addition, this adjustment may include additional accreditation costs expected to be incurred during the year for which the payment rates are being computed. For purposes of determining expected accreditation costs to be incurred during the rate year the Governor's Executive Budget submission to the legislature shall be utilized.

[VI. CAPITAL-RELATED COSTS

The inpatient Medicaid payment rates for OMH facilities shall include an allowance for depreciation and interest expense on buildings and equipment. Depreciation expense shall be computed utilizing the straight line method. Useful lives of depreciable assets shall be applied based upon the guidelines promulgated by the American Hospital Association.

The capital component of the rates shall be computed on a current basis. Accordingly the rates will reflect a projection of capital costs and patient days applicable to the rate year. A per diem adjustment shall be included in subsequent years rates to reflect any differences between projected and actual costs and patient days used in the calculation of the rate year capital per diem.]

VII. VOLUME ADJUSTMENT

A per diem adjustment will be incorporated in the inpatient Medicaid rates for OMH facilities to account for

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significant changes in costs due to significant changes in the number of patient days. The adjustment will be made only if the change in total inpatient days between the base year and the rate year exceeds two percent (2%). In calculating the rate adjustment, it will be recognized that all the facility's capital costs are fixed. Operating costs will be considered eighty percent (80%) fixed and twenty percent (20%) variable. Under this formula if days increase more than two percent (2%), the rate for the applicable rate category will be reduced to allow only twenty percent (20%) of the operating per diem for the additional days. Alternatively, if days decrease over two percent (2%), the rate for the applicable rate category will be increased to allow eighty percent (80%) of the operating per diem for the lost days to be spread over the actual days for the rate period.

An estimated volume adjustment will be calculated and included in the rate calculation. The estimated volume adjustment will be calculated based upon the projected patient days for the upcoming rate year vs. the actual patient days for the base year used to calculate the rates. Following the close of the rate year a comparison would be made between the projected days used in calculating the estimated volume adjustment and the actual days incurred for the rate year. The volume adjustment will then be recalculated to reflect the actual days for the rate year. The difference, if any, between the estimated volume adjustment and the final actual volume adjustment will be included as a retroactive adjustment in the rate for the following year.

VIII. REDUCED PAYMENT FOR INAPPROPRIATE LEVEL OF CARE

If it is determined by a utilization review committee that a Medicaid recipient no longer requires psychiatric hospital services but must remain in the hospital because a medically necessary skilled nursing facility or intermediate care facility bed is not available in the community ("alternate care day") and it is determined that the statewide rate of occupancy

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Supersedes TN 89-14 Effective Date APR 1 - 1990

- 5a -

of operational beds at OMH hospitals is less than 80%, the hospital will be reimbursed at the average Medicaid skilled nursing facility or intermediate care facility rate within the State, as appropriate. Operational beds are defined as the projected census for the upcoming year for the Office of Mental Health psychiatric hospital system as derived from the Executive Budget. In determining whether the statewide occupancy rate meets the 80% requirement, for purposes of determining the applicable reimbursement rate, alternate care days will not be counted as occupied beds.

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IX. DISPROPORTIONATE SHARE ADJUSTMENT

The Medicaid payment rates for OMH facilities will be adjusted in accordance with Sections 1902 (a)(13)(A) and 1923 of the Social Security Act to account for the situation of OMH facilities which serve a disproportionate number of low income patients with special needs. The adjustment will be made if either the Medicaid inpatient utilization rate for OMH hospitals is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or if the low income utilization rate for OMH hospitals exceeds 25 percent.

The Medicaid inpatient utilization rate is defined as the total number of Medicaid inpatient days in a cost reporting period divided by the total number of the hospitals inpatient days in that same period.

The low income utilization rate is defined as the sum (expressed as a percentage) of the fraction calculated as follows:

- o Total Medicaid patient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments for the latest available cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period; and,
- o The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period less the portion of cash subsidies reasonably attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient service in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third-party payers, such as HMO's, Medicare or Blue Cross.

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Supersedes 91-12

APR 10 1997

Those OMH hospitals that qualify as a disproportionate share hospital will receive a payment adjustment to fully reimburse the hospital for the unreimbursed costs incurred in providing services to individuals who are either eligible for medical assistance or who have no health insurance or other source of third party coverage for the services provided.

X. DISPROPORTIONATE SHARE LIMITATIONS

Effective April 1, 1994, and thereafter, for OMH facilities, disproportionate share payment distributions made pursuant to this Part of this Attachment shall be limited in accordance with the provisions of this section.

Effective April 1, 1994, OMH facilities whose inpatient Medicaid eligible patient days are less than one percent of total inpatient days shall not be eligible to receive disproportionate share distributions.

Effective for the state fiscal year beginning April 1, 1994, disproportionate share payments to OMH facilities with inpatient Medicaid eligible patient days, as a percentage of total inpatient days, of at least one standard deviation above the statewide mean Medicaid patient day percentage shall be increased to 200 percent of the disproportionate share limit determined in accordance with this section. This increase shall be contingent upon acceptance by the Secretary of the federal Department of Health and Human Services of the Governor's certification that the hospital's applicable minimum amount is used for health services during the year. Federal funds associated with payments to OMH facilities in excess of 100 percent of unreimbursed costs shall not be distributed unless OMH submits to the Commissioner a written certification stating that all distributions in excess of the 100 percent limit will be used for health services.

*repeated  
language  
from  
previous  
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94-26*

TN 97-13

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No OMH facility shall receive in total from disproportionate share payment distributions an amount which exceeds the costs incurred for furnishing inpatient and ambulatory hospital services to individuals who are eligible for Medicaid benefits pursuant to title XIX of the federal Social Security Act or to individuals who have no health insurance or other source of third party coverage, reduced by medical assistance payments made pursuant to Title XIX of the federal Social Security Act, other than disproportionate share payments, and payments by uninsured patients. For purposes of this section, payments to OMH facilities for services provided to indigent patient made by the State of a unit of local government within the State shall not be considered a source of third party payment.

For purposes of calculating disproportionate share (DSH) distributions pursuant to this section, if the hospital receiving the distribution is a public hospital (operated by the State, a city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a "high DSH" facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as "high DSH", payments made during a distribution period shall equal 200 percent of the amount described in the previous sentence. To be considered a "high DSH" facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospital receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period.

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Previous years' data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient cost shall be made upon receipt of an appropriate report.

Facility specific limitations will be estimated before the beginning of each fiscal year. The estimate will be based on the most recently available actual cost and revenue information as adjusted for expected changes in cost and revenue. These estimated facility-specific limitations will be recalculated to reflect actual information after the year has been completed and the necessary information has been compiled. Once the actual limitations for the year are known, adjustments will be made as necessary to the disproportionate share amounts paid to the facility. If it is determined that disproportionate share payments to a particular facility exceeded the facility-specific calculation, a recoupment will be made. Alternatively, if it is determined that additional disproportionate share payments are due the facility, such additional payments will be made.

XI. TRANSFER OF OWNERSHIP

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

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by total patient discharges expressed as a percentage. The percentages shall be calculated based upon 1989 data developed by the Office of Mental Health.

The scale utilized for development of a supplementary low income patient adjustment for a public psychiatric hospital shall be as follows:

Low Income Patient Percentages	Supplemental Percentage Coverage of Need
35+ to 55%	20%
55+ to 60%	25%
60+ to 65%	30%
65+ to 70%	37.5%
70+%	45%

[The supplemental percentage coverage of need shall not be allocated between case based and exempt units and the low income patient percentage for public psychiatric hospitals shall be calculated based on 1989 data developed by the Office of Mental Health.] The adjustment for public psychiatric hospitals shall be limited such that this amount when added to the disproportionate share adjustment described above shall not exceed 90% of need.

X. DISPROPORTIONATE SHARE LIMITATIONS

Effective April 1, 1994, and thereafter, for OMH facilities, disproportionate share payment distributions made pursuant to

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Supersedes TN 94-16 Effective Date APR 01 1994

this Part of this Attachment shall be limited in accordance with the provisions of this section.

Effective April 1, 1994, OMH facilities whose inpatient Medicaid eligible patient days are less than one percent of total inpatient patient days shall not be eligible to receive disproportionate share distributions.

Effective for the state fiscal year beginning April 1, 1994, disproportionate share payments to OHM facilities with inpatient Medicaid eligible patient days, as a percentage of total inpatient patient days, of at least one standard deviation above the statewide mean Medicaid patient day percentage shall be increased to 200 percent of the disproportionate share limit determined in accordance with this section. This increase shall be contingent upon acceptance by the Secretary of the federal Department of Health and Human Services of the Governor's certification that the hospital's applicable minimum amount is used for health services during the year. Federal funds associated with payments to OMH facilities in excess of 100 percent of unreimbursed costs shall not be distributed unless OMH submits to the Commissioner a written certification stating

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Supersedes TN New Effective Date APR 01 1994

that all distributions in excess of the 100 percent limit will be used for health services.

No OMH facility shall receive in total from disproportionate share payment distributions an amount which exceeds the costs incurred for furnishing inpatient and ambulatory hospital services to individuals who are eligible for Medicaid benefits pursuant to title XIX of the federal Social Security Act or to individuals who have no health insurance or other source of third party coverage, reduced by medical assistance payments made pursuant to Title XIX of the federal Social Security Act , other than disproportionate share payments, and payments by uninsured patients. For purposes of this section, payments to OMH facilities for services provided to indigent patients made by the State or a unit of local government within the State shall not be considered a source of third party payment.

For purposes of calculating disproportionate share (DSH) distributions pursuant to this section, if the hospital receiving the distribution is a public hospital (operated by the State, a

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city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a "high DSH" facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as "high-DSH", payments made during a distribution period shall equal 200 percent of the amount described in the previous sentence. To be considered at "high-DSH" facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period. Previous years' data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient costs shall be made upon receipt of an appropriate report.

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Facility specific limitations will be estimated before the beginning of each fiscal year. The estimate will be based on the most recently available actual cost and revenue information as adjusted for expected changes in cost and revenue. These estimated facility-specific limitations will be recalculated to reflect actual information after the year has been completed and the necessary information has been compiled. Once the actual limitations for the year are known, adjustments will be made as necessary to the disproportionate share amounts paid to the facility. If it is determined that disproportionate share payments to a particular facility exceed the facility-specific calculation, a recoupment will be made. Alternatively, if it is determined that additional disproportionate share payment are due the facility, such additional payments will be made.

XI. TRANSFER OF OWNERSHIP

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, the valuation of the

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asset after such change in ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

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XI. Additional Disproportionate Share Payment

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below and are made in addition to, and not as a substitute for, the disproportionate share adjustment described in section IX. However, the calculations of hospitals' bad debt and charity care costs which are partially covered by the disproportionate share adjustment described in section IX, does not include costs of services to any person for whom an additional disproportionate share payment has been made under this section.

These additional payment adjustments are made either by the Department or through an intermediary to disproportionate share hospitals ~~whowhich~~ which have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program (except for their current residential status). These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital, or an intermediary making a payment to a hospital, will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

TN 96-40B

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Part II

A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above, and meets the requirements of State Plan Amendment 94-26. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments either from the State directly, or through an intermediary, to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process, or intermediary payment process; and according to established rates or fees, for fee-for-service program services or by the intermediary for its services. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department, or the intermediary, as appropriate.

Disproportionate share payments under this plan cannot exceed the State disproportionate share allotment calculated in accordance with the provision of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (P.L. 102-234), as set forth at 42 CFR Sections 447.296 through 447.299, and cannot exceed the facility specific disproportionate share payment limits required by the Omnibus Budget Reconciliation Act of 1993.

TN 96-40B Approval Date MAY 14 2001  
Supersedes TN 91-58 Effective Date SEP 26 1996

METHODS AND STANDARDS OF SETTING PAYMENT RATES FOR  
HOSPITALS LICENSED BY THE OFFICE OF MENTAL HEALTH

In accordance with the New York State Mental Hygiene Law, the State's Office of Mental Health establishes Medicaid rates of reimbursement for hospitals issued operating certificates by the Office of Mental Health. The class of facilities defined as hospitals includes the subclass of Residential Treatment Facilities for Children and Youth ("RTFs") which furnish inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs. Medicaid rates established by the Office of Mental Health must be certified by the Commissioner and approved by the Director of the Budget. The Methods and Standards set forth below do not apply to hospitals operated by the Office of Mental Health or to hospitals licensed by the Department of Health.

A. HOSPITALS OTHER THAN RESIDENTIAL TREATMENT  
FACILITIES FOR CHILDREN AND YOUTH

1. OPERATING COSTS

Medicaid rates are established prospectively and are all inclusive, taking into account all allowable patient days and all allowable costs and are effective for a twelve month period. Payment rates for a rate year are based on base year financial and statistical reports submitted by hospitals to the Office of Mental Health. The base year is the fiscal year two years prior to the rate year. The financial and statistical reports are subject to audit by the Office of Mental Health.

Allowable base year operating costs are determined by the application of the principles developed for determining reasonable cost payments under the Medicare program. To be allowable, costs must be reasonable and must relate to patient care. Allowable costs may not include costs for services which have not been approved by the Commissioner.

Hospitals which have no previous costs or operating experience will submit a budget report as the basis for calculating a prospective Medicaid rate. The budget report will contain all proposed revenues and expenses for the period under consideration. The operating cost component of the rate will be the lower of the calculated per diem, utilizing the approved budgeted operating costs and the approved budgeted patient days, or 110% of the statewide weighted average of the operating cost component of all private psychiatric hospitals. The hospital is required to submit a cost report after it has operated for six months at a minimum occupancy level of at least 75%. This cost report will be used to set a cost based rate for the hospital effective the first day of the cost report period.

TN 92-15

Approval Date JUN 29 1992

Effective Date MAY 29 1992

In determining allowable operating costs for any base year there is applied a limitation, which is derived from the fiscal year one year prior to the base year, increased by the Medicare inflation factor for hospitals and units excluded from the prospective payment system. Both the base year and the limitation are subject to an administration cost screen. The administration cost screen is derived from the costs in the fiscal year one year prior to the base year (i.e. the same cost year the limitation is derived from), and is the group average cost plus ten percent. Separate administration cost screens are calculated for hospitals greater than 100 beds (group one), and hospitals less than 100 beds (group two). The allowable costs are the lesser of the base year operating costs or the limitation. The allowable operating costs are then increased for inflation to the rate year by the Medicare inflation factor described above, except that the 1996 Medicaid rates will not include an inflation factor for 1996 effective July 1, 1996, and the 2010 Medicaid rates will not include an inflation factor for 2010 effective January 1, 2010. Such inflation factor shall be as determined by the Federal Government each year prior to the effective date of the payment rates calculated herein.

Appeals from rate determinations are heard by the Commissioner. The Commissioner may hear requests for rate revisions which are based on errors in the calculation of the rate or in the data submitted by the facility or based on significant changes in operating costs resulting from changes in services, programs or capital projects approved by the Commissioner in connection with OMH's certificate of need procedures. Revised rates must be certified by the Commissioner and approved by the Director of the Budget.

## 2. CAPITAL COSTS

To allowable operating costs are added allowable capital costs. Allowable capital costs are determined by the application of the principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. To be allowable, capital expenditures subject to the Office of Mental Health's certificate of need procedures must be reviewed and approved by the Office of Mental Health.

The allowed capital cost component of the budget based rate will be based upon approved annual budgeted costs and approved budgeted patient days retroactively adjusted to actual certified costs divided by the higher of the actual patient days or the approved budgeted patient days.

### Transfer of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a hospital which has undergone a change of ownership, that the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

TN 10-01

Supersedes TN 96-38

Approval Date AUG 25 2010

Effective Date JAN - 1 2010

3. REDUCED PAYMENT FOR INAPPROPRIATE LEVEL OF CARE

If it is determined by a utilization review committee that a Medicaid recipient no longer requires inpatient psychiatric hospital services but must remain in the hospital because a medically necessary long term care bed is not available in the community ("alternate care determination"), and it is determined by the Commissioner that there is a significant excess of operational beds at the hospital or in private psychiatric hospitals located in the OMH region in which the hospital is located, the hospital will be reimbursed at a rate equal to the average Medicaid skilled nursing facility or intermediate care facility rate within the State, as appropriate, at the time such services were furnished. For purposes of this paragraph, a significant excess of operational beds exists if the occupancy rate for the hospital for the most recently reported twelve month period is less than 80%, of the hospital's bed capacity, as stated on the operating certificate issued by the Office of Mental Health. A significant excess of operational beds exists in the OMH region if the overall occupancy rate for private psychiatric hospitals in the region is less than 80%. Alternate care days are counted as occupied beds. Effective October 1, 1984, occupancy rates will be determined without including alternate care days.

Alternate care determinations must be reported to the Office of Mental Health ("OMH") on such forms and in such manner as shall be prescribed by OMH. OMH will notify providers of procedures for collecting and reporting data.

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TN 92-15 4 Approval Date JUN 23 1992  
Supersedes TN 91-15 Effective Date MAY 28 1992.

4. Additional Disproportionate Share Payment

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below.

These additional payment adjustments are made either by the Department or through an intermediary to disproportionate share hospitals which have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital, or an intermediary making a payment to a hospital, will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

TN 96-40B Approval Date MAY 14 2001  
Supersedes TN 91-58 Effective Date SEP 26 1996

New York

Attachment 4.19-A  
Part III  
Page 2C

A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above, and meets the requirements of State Plan Amendment 94-26. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments either from the State directly, or through an intermediary, to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process, or intermediary payment process, and according to established rates or fees, for fee-for-service program services or by the intermediary for its services. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department, or the intermediary, as appropriate.

Disproportionate share payments under this plan cannot exceed the State disproportionate share allotment calculated in accordance with the provision of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (P.L. 102-234), as set forth at 42 CFR Sections 447.296 through 447.299, and cannot exceed the facility specific disproportionate share payment limits required by the Omnibus Budget Reconciliation Act of 1993.

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New York

Revised RTF 1996-1997  
96-37

ATTACHMENT 4.19-A Part III page 3

B. RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN AND YOUTH

Medicaid rates for Residential Treatment Facilities for Children and Youth ("RTFs") are established prospectively, based upon actual costs and patient days as reported on cost reports for the fiscal year two years prior to the rate year. The RTF fiscal year and rate year are for the twelve months July 1 through June 30. Actual patient days are subject to a maximum utilization of 98 percent and a minimum utilization of 95 percent. For the rate years July 1, 1994 through June 30, 1995 and July 1, 1995 through June 30, 1996 the base year for both rate years for the purpose of setting rates will be July 1, 1992 through June 30, 1993.

1. OPERATING COSTS

Allowable operating costs are subject to the review and approval of the Office of Mental Health. In determining the allowability of costs, the Office of Mental Health reviews the categories of cost, described below, with consideration given to the special needs of the patient population to be served by the RTF. The categories of costs include:

- (i) Clinical Care. This category of costs includes salaries and fringe benefits for clinical staff.
- (ii) Other than Clinical Care. This category of costs includes the costs associated with administration, maintenance and child support.

Allowable per diem operating costs in the category of clinical care are limited to the lesser of the reported costs or the amount derived from the number of clinical staff approved by the Commissioner multiplied by a standard salary and fringe benefit amount. Clinical services such as dental services, purchased on a contractual basis will be considered allowable and not subjected to the clinical standard if the services are not uniformly provided by all RTFs and thus not considered by the Commissioner in the establishment of the approved staffing levels.

Allowable per diem operating costs in the category of other than clinical care are limited to the lesser of the reported costs or a standard amount.

The standard amounts for the clinical and other than clinical categories are computed as follows. For RTFs located in the New York, City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50% of the average per diem cost for all RTFs in this geographic area and 50% of the average per diem cost for all RTFs in the state; increased by [five] seven and one half percent. For RTFs located outside the New York, City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50% of the average per diem cost for all RTFs located outside the New York City metropolitan statistical area and Nassau and Suffolk Counties and 50% of the average per diem cost for all RTFs in the state; increased by [five] seven and one half.

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Allowable operating costs as determined in the preceding paragraphs will be increased annually by the Medicare inflation factor for hospitals and units excluded from the prospective payment system except for the rate periods effective July 1, 1995 through June 30, 1996, and July 1, 2009 through June 30, 2010, where no inflation factor will be used to trend costs. **[beyond the July 1, 1994 through June 30, 1995 period, and the July 1, 2009 through June 30, 2010 period, where the inflation factor used to trend costs will be limited to the inflation factor for the first year of the two year period.]**

## 2. CAPITAL COSTS

To allowable operating costs are added allowable capital costs. Allowable capital costs are determined by the application of principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. To be allowable, capital expenditures which are subject to the Office of Mental Health's certificate of need procedures must be reviewed and approved by the Office of Mental Health.

### Transfer of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, that the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

## 3. APPEALS

The Commissioner may consider requests for rate revisions which are based on errors in the calculation of the rate or in the data submitted by the facility or based on significant changes in operating costs resulting from changes in service, programs, or capital projects approved by the Commissioner in connection with OMH's certificate of need procedures. Other rate revisions may be based on additional staffing required to meet accreditation standards of the Joint Commission on Accreditation of Hospitals, or other Federal or State mandated requirements resulting in increased costs. Revised rates must be certified by the Commissioner and approved by the Director of the Budget.

4. RESIDENTIAL TREATMENT FACILITIES WITH INADEQUATE COST EXPERIENCE

Rates of payment for a residential treatment facility with inadequate cost experience shall be determined on the basis of satisfactory cost projections as submitted to the Commissioner. The rate of payment shall take into consideration total allowable costs, total allowable days and shall be subject to staffing standards as approved by the Commissioner and a limitation on operating expenses as determined by the Commissioner.

Financial reports, reflecting actual cost and statistical information, in a form prescribed by the Commissioner, shall be required within one hundred twenty days following the first six month period during which the Residential Treatment Facility has operated at an average utilization of at least ninety percent or one

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year after the first resident was admitted to the Residential Treatment Facility, whichever event occurs earlier. The Commissioner may, at his discretion, utilize this cost report to adjust the RTF's budget-based rate of payment to more accurately reflect the costs of operating the facility. In any event, the Commissioner will calculate a cost-based rate for the facility no later than two years after the facility has opened, unless the Commissioner determines that the facility has not achieved the status of a stable, ongoing operation with reliable cost information, in which case the budget based rate will be continued, adjusted as necessary, for updated budget projections as appropriate.

**5. REDUCED PAYMENT FOR INAPPROPRIATE LEVEL OF CARE**

Effective twelve months after the date the RTF submits financial reports reflecting actual operating costs or two years after the RTF begins operating, whichever is earlier, if it is determined by a utilization review committee that a Medicaid recipient no longer requires inpatient psychiatric hospital services but must remain in the RTF because a medically necessary long term care bed is not available in the community, and it is determined by the Commissioner that there is a significant excess of operational beds at the RTF or in the RTFs located in the OMH region in which the RTF is located, the RTF will be reimbursed at a rate equal to the average Medicaid skilled nursing facility or intermediate care facility rate within the State, as appropriate, at the time such services are furnished. For purposes of this paragraph, a significant excess of operational beds exists if the occupancy rate for the RTF for the most recently reported twelve month period is less than 80% in the case of RTFs with certified bed capacities greater than 20 beds or 60% in the case of RTFs with certified bed capacities of 20 beds or less, as stated on the operating certificate issued by the Office of Mental Health. A significant excess of operational beds exists in an OMH region if the overall occupancy rate for RTFs in the region is less than the weighted average of 80% for RTFs in the region with certified bed capacities greater than 20 beds and 60% for RTFs in the region with certified bed capacities of 20 beds or less. The occupancy rate shall be determined without including alternate care days. The determination of average occupancy rate for RTFs in the region is applied to each of the five geographical OMH regions and is based on RTFs which are subject to the provisions of this section and which are located within the same OMH Region.

Alternate care determinations must be reported to the Office of Mental Health on such forms and in such manner as shall be prescribed by OMH. OMH will notify providers of procedures for collecting and reporting data prior to the effective date of the reduced payment provision.

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Supersedes TN 90-43 Effective Date JUL 1 1991

6. Additional Disproportionate Share Payment

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below.

These additional payment adjustments are made either by the Department or through an intermediary to disproportionate share hospitals which have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital, or an intermediary making a payment to a hospital, will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

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Supersedes TN 91-58 Effective Date SEP 26 1996

A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the State to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process and according to established rates or fees. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department.

For purposes of calculating disproportionate share (DSH) distributions pursuant to this section, if the hospital receiving the distribution is a public hospital (operated by the State, a city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a "high DSH" facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as "high-DSH", payments made during a distribution period shall be limited to 200 percent of the amount described in the previous sentence. To be considered a "high-DSH" facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period. Previous years' data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient costs shall be made upon receipt of an appropriate report.

97-13

JUN 06 2001

Supersedes TR 94-26 Effective Date APR 10 1997

(96-408)

**New York State Office of Alcoholism  
and Substance Abuse Services (OASAS)**

**SUMMARY OF INPATIENT MEDICAID  
PAYMENT METHODOLOGY FOR SERVICES IN  
PRIVATE PSYCHIATRIC HOSPITALS**

OASAS establishes all inclusive program specific per diem rates on a prospective basis. Rates are established on the basis of certified cost reports which are submitted at least one year prior to the first day of the rate year which is the calendar year. For example, rates for the 1994 calendar year rate year were based upon 1992 calendar year data. A rolling base year is utilized, i.e. each year, rates are re-calculated using a new base year.

Allowable operating and capital costs from the base year are determined in accordance with Medicare Principles of Reimbursement (HIM-15) and Generally Accepted Accounting Principles (GAAP). Increases in operating costs from base year to base year are limited by application of a growth factor. The growth factor changes each year and is defined as the trend factor for the base year plus 2%.

A trend factor is then added to the lower of a program's base year operating costs or the operating costs as limited by the growth factor. The trend factor is developed for OASAS by the NYS Office of Health Systems Management (OHSM). The trend factor has two components, personal services and non-personal services. Calculation of the personal services component is multi-step process. First, personal services costs are broken down into various categories, i.e., managerial and administrative, professional and technical, clerical, service occupations and blue collar. Each category is then assigned a sub-weight representing its percentage relationship to total personal services costs. The assigned subweight is then multiplied by the price movement for each of these categories using United States Department of Labor, Bureau of Labor statistics. The sum percentage of these calculations is then multiplied by a percentage representing personal services costs to total costs. The non personal services component is determined by multiplying the GNP implicit price deflator by a percentage representing non personal costs to total costs. The trend factor for the 1994 rate year is 2.99%.

The program specific per diem rate is then calculated by dividing the sum of allowable trended adjusted operating costs and allowable capital costs by the higher of actual patient days (in the base year) or 90% of possible base year days for inpatient rehabilitation programs; for primary care (detoxification) programs, the higher of actual base year patient days or 85% of possible base year days is used. Possible days for each program is calculated by multiplying the certified bed capacity by the number of days in the base year, i.e. either 365 or 366. Rates which are based upon actual certified costs data are provisional pending audit. There is a process for a provider to appeal a provisional rate.

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Supersedes TN 1004 Effective Date APR - 1 1994

For new providers with inadequate cost experience, rates are calculated on the basis of a program specific 12 month budgeted cost report. As with actual cost based rates, allowable operating and capital costs are determined in accordance with HIM-15 and GAAP. Unlike actual cost based programs, operating costs will be limited to 115% of the statewide average for similar programs. The sum of allowable adjusted operating costs and allowable capital costs is then divided by the higher of budgeted days or 90%/85% of possible days to arrive at a budgeted per diem. Budgeted based rates are adjusted to actual rates upon receipt of actual certified cost reports. Program specific provisional rates are then established retroactively to the effective date of the budgeted rate.

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Supersedes TN New Effective Date APR - 1 1994

***New York State Office of Alcoholism  
and Substance Abuse Services (OASAS)***

**Inpatient Psychiatric Services for Individuals under 21**

Inpatient Psychiatric Services for individuals under 21 who are admitted to Residential Rehabilitation Services for Youth programs that are certified by the New York Office of Alcoholism and Substance Abuse Services. Services are limited to those provided for those recipients who are medically certified as requiring this level of care in accordance with 42 CFR 441.152. Services are limited to individuals under the age of twenty-one (21), or receiving services immediately before attaining the age of twenty-one (21), not to extend beyond the earlier of:

- (1) the date the services are no longer required; or
- (2) the date the individual reaches the age of twenty-two (22).

Coverage of services will be limited to those services provided within a residential rehabilitation services program for youth that is certified by the New York Office of Alcoholism and Substance Abuse Services.

**Residential Rehabilitation Services for Youth**

Medicaid fees for Residential Rehabilitation Services for Youth ("RRSY") services are established using a cost model based on service requirements established by the Commissioner of the Office of Alcoholism and Substance Abuse Services ("the office") pursuant to regulation at 14 New York Code of Rules and Regulations Part 817 ("Part 817").

**Definitions.**

- (1) "Eligible residential rehabilitation services for youth provider" shall mean a residential rehabilitation services for youth provider that has been certified by the Office to provide services pursuant to Part 817.
- (2) "Allowable costs" shall mean those costs incurred by an eligible residential rehabilitation services for youth provider which are eligible for Medicaid payments. To be allowable, costs must be reasonable and necessary for efficient provision of chemical dependence services, related to patient care, recurring, and approved by the commissioner.

TN#: 05-54 Approval Date: JUN - 1 2006  
Supersedes TN#: NEW Effective Date: JAN - 1 2006

(3) "Patient day" shall mean the unit of measure denoting lodging provided and services rendered to one patient between the census-taking hours on two successive days. A patient day is counted on the day of admission but not on the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(4) "Allowable days" shall mean the total of patient days provided by an eligible residential rehabilitation services for youth provider.

(5) "Fee Period" shall be the calendar year.

(6) "Base year" shall mean the period from which fiscal and patient data are utilized to calculate rates of payment for the fee period.

(7) "Fee Cycle" shall mean either one fee period or more than one consecutive fee periods. Such fee or fees shall be derived from a common base year.

(8) "New eligible residential rehabilitation service for youth provider" shall mean an eligible RRSY provider for which relevant historical chemical dependence service costs are not available.

(9) "Service operating fee" shall mean fees calculated as payment in full for operating expenses as required by Part 817. Such fee shall not include the capital add-on.

(10) "Capital add-on shall mean a provider-specific cost based per diem to address allowable and approved real property, equipment and start-up costs not included in the service operating fee.

**Calculation of service operating fees.**

Service operating fees for RRSY shall be developed by the office using a cost model based on the requirements of Part 817. The cost model shall contain personal service and non-personal service costs. The cost model shall recognize cost differentials between the upstate and downstate regions of the state and also cost differentials between providers with differing service capacities. The service operating fees shall be deemed to be inclusive of all service delivery operating costs and shall be considered payment in full to the residential rehabilitation services for youth provider for all non-capital costs related to delivery of services provided pursuant to Part 817.

TN#: 05-54

Approval Date: JUN - 1 2006

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Effective Date: JAN - 1 2006

(1) For purposes of this section, the upstate and downstate geographic regions are defined as follows:

- (i) The downstate region includes New York City and the counties of Nassau, Suffolk, Westchester, Rockland and Putnam. New York City includes the counties of New York, Bronx, Kings, Queens and Richmond.
- (ii) The upstate region includes all other counties in New York State.

(2) Within each geographic region, four service operating fees shall be developed based on differing service capacities. The applicable fee for a given RRSY facility shall be determined based on the region in which the facility is located and the RRSY provider's statewide certified RRSY capacity.

(3) The service operating fees for each fee cycle shall be developed by using base year patient and fiscal data. The base year fee calculation shall then be trended, using the Congressional Budget Office's Consumer Price Index for all Urban Consumers, to the first day of the fee cycle. The personal service component of the service operating fees shall be calculated by the office using the staffing requirements of Part 817 in conjunction with the applicable U.S. Department of Labor's Employment and Wage Estimates, as adapted by the office to coincide with the staffing position titles of Part 817 and the geographic regions defined above. The fringe benefits, non-personal service and administrative components of the service operating fees shall be calculated by the office using fringe benefit, non-personal service and administrative fiscal data for providers operating RRSY.

(4) The initial base year shall be 2002. The first day of the initial fee cycle shall be 1/1/2005. The service operating fees, effective 1/1/2005, shall be:

Fee Level	Provider's State-Wide Certified Capacity	Upstate Fee	Downstate Fee
Level 1	10 - 14	\$349.69	\$394.96
Level 2	15 - 39	\$266.58	\$299.81
Level 3	40 - 89	\$174.75	\$194.65
Level 4	90 or greater	\$151.07	\$167.22

Prior to implementation these fees will be trended to first day of the fee period of implementation in accordance with number (5) below.

(5) Each year a trend factor based on the Congressional Budget Office's Consumer Price Index for all Urban Consumers shall be applied to all components of the service operating fee. The trend factor shall not apply to the capital add-on to the service operating fee.

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 Supercedes TN#: NEW Effective Date: JAN - 1 2006

(6) With the approval of CMS, the service operating fees may be updated to adjust for programmatic changes or service operating cost variations not addressable by the annual trend factor. The process of updating service operating fees may include one of more of the following:

- (i) the establishment of a new base year and fee cycle;
- (ii) a change in the number of fee levels;
- (iii) a change in the upper and/or lower service capacities of the fee levels; or
- (iv) other necessary changes not specifically addressed above.

**Capital add-on.**

To be considered as allowable, capital costs must be both reasonable and necessary to patient care under Part 817. Allowable capital costs shall be determined in accordance with the following:

(1) The office shall use, as its major determining factor in deciding on the allowability of costs, the most recent edition of the Medicare Provider Reimbursement Manual, commonly referred to as HIM-15, published by the U.S. Department of Health and Human Services' Centers for Medicare and Medicare Services.

(2) Where HIM-15 is silent concerning the allowability of costs, the commissioner shall determine allowability of costs based on reasonableness and relationship to patient care and generally accepted accounting principles.

Allowable capital costs may include:

- (1) the costs of owning or leasing real property;
- (2) the costs of owning or leasing moveable equipment and personal property; and
- (3) the cost of up to three months of pre-operational program start-up expenses, and associated interest, for new services, programs, or facilities for which initial reimbursement levels are being established. Pre-operational start-up costs may include, but are not limited to, rent, employee compensation, utilities, staff training and travel, and expensed equipment.

No capital or start-up expenditures for which approval by the office is required in accordance with the operating requirements of the office shall be included in allowable capital costs for purposes of computation of provider reimbursement unless such approval shall have been secured. For projects requiring approval by the office, reimbursement for capital costs shall be limited to the amount approved by the commissioner. To be considered allowable for

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reimbursement, capital and start-up costs must be both reasonable and necessary, incurred by the provider, and chargeable to necessary patient care.

The capital add-on to the service operating fee shall be calculated for each fee period on a provider-specific basis by dividing the provider's allowable capital costs for that fee period by the allowable patient days for that fee period. The capital add-on may be adjusted by the office on a retroactive or prospective basis to more accurately reflect the actual or anticipated approved capital cost.

**New eligible RRSY providers.**

(1) Once a new eligible RRSY provider has at least six months of cost and operating experience, they shall submit reports at least 180 days prior to the beginning of the fee period for which a fee is being requested unless otherwise waived by the commissioner.

(2) Each new eligible RRSY provider which has less than six months of cost and operating experience shall prepare and submit to the commissioner a budgeted cost report. Such report shall:

- (i) include a detailed projection of revenues and a line item expense budget with regard to staffing, non-personal service costs including capital;
- (ii) include a detailed staffing plan;
- (iii) include a projected month by month bed utilization by program;
- (iv) cover a 12 month period; and
- (v) such budget report shall be completed and submitted at least 180 days prior to the beginning of the rate year for which a rate is being requested.

(3) The service operating fee and capital add-on for each new eligible RRSY provider shall be calculated and reimbursed pursuant to these requirements.

(4) Upon submission of the financial reports the commissioner may adjust retroactively the eligible RRSY provider's existing capital add-on to more accurately reflect the reported operating costs and program utilization, based on patient days of the eligible RRSY provider.

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Attachment 4.19-A

Part ~~III~~  
IV

METHODS AND STANDARDS FOR SETTING PAYMENT RATES

FINGER LAKES AREA HOSPITALS

87-10

*supersedes*

Approval Date APR 15 1988

Effective Date JAN 1 1987

FINGER LAKES HOSPITAL EXPERIMENTAL PAYMENT PROGRAM TITLE XIX  
(MEDICAID) STATE PLAN AMENDMENT

BACKGROUND

The Finger Lakes Hospital Experimental Payment Program (FLHEP) was implemented as of January 1, 1981 as a Medicare and Medicaid demonstration system under the authority of sections 402 and/or 222 of the Social Security Amendments of 1967 and 1972, respectively. This program continued until December, 1986. From January 1, 1987 to December 31, 1994, the Finger Lakes Area Hospitals' Corporation (FLAHC) had received approval from the Federal Health Care Financing Administration (HCFA) for a waiver of Medicare reimbursement principles, to permit the continuation of the Finger Lakes Hospital Experimental Payment Program system under the authority of section 1886(c) of the Social Security Act, as amended. Section 1886(c) requires that the State hospital reimbursement control system for which a Medicare waiver is granted also apply to Medicaid revenues and expenses. Hence, in 1987, FLHEP was continued as a cost control system under section 1886(c) (known as FLHEP-2) rather than as a demonstration system. FLHEP was also continued for the 1988-1990 periods as FLHEP-3, and for the 1991-1993 periods (as FLHEP-4). FLHEP will continue as a cost control system under section 1886(c) for the period January 1, 1994 through June 30, 1996 as FLHEP-4E and for the period July 1, 1996 through December 31, 1996 as FLHEP-4EE. For 1995 and 1996, FLAHC member hospitals will no longer be covered under a waiver of section 1886(c) of the Social Security act. Beginning in 1995 member hospitals will be reimbursed for Medicare patients in the same manner as other hospitals in New York State. Medicaid and Blue Cross continue to be participating payers in the FLHEP system. The hospitals participating in this program are F. F. Thompson, Geneva General, Myers Community, Newark-Wayne Community, and Soldiers and Sailors.

SYSTEM OVERVIEW

For the period January 1, 1996 through December 31, 1996, all FLHEP hospitals will continue to participate in a total revenue system, with the revenue allocated among Medicare and non-Medicare payers using standard Medicare apportionment techniques. Inpatient reimbursement for all major third-party payers (Medicaid, Blue Cross) will be through a DRG-based case payment methodology similar to the case payment methodology followed by New York State for its non-Medicare inpatients. The case payment rates for the participating hospitals will be based on their historical payment base (1987 costs trended forward and adjusted). The design of FLHEP-4E and FLHEP-4EE includes continuation of the demonstration for the use of a severity measure that was started under the FLHEP-3 contract. Medicaid funds will be used to fund inpatient services only. The severity study will be funded from a statewide pool in which there is no federal financial participation.

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Supervisor's File 95-02 Effective Date JAN - 1 1996

This plan covers the third year extension of the FLHEP-4 contract which runs through December 31, 1996. Extending this Agreement will continue all existing FLHEP programs while providing the Finger Lakes Corporation sufficient time to transition to a modified reimbursement system.

The FLHEP-4E and 4 contracts, like the previous FLHEP contracts, are based on the concept of regional cooperation in the planning and delivery of services in the most cost effective manner possible. To that end, the participating hospitals shall engage in cooperative community service planning to ensure that changes in services or facilities continue to conform to this concept of cost effective delivery and organization of care in the area.

To calculate the rates, FLHEP-2 1987 hospital costs are aggregated and allocated to each member hospital using the following percentages:

FF Thompson Hospital	22.8119%
Geneva General Hospital	32.1315%
Myers Community Hospital	11.1376%
Newark-Wayne Community Hospital	24.4871%
Soldiers and Sailors Memorial Hospital	9.4318%

This cost, also known as the gross aggregate dollar amount, is the basis for the FLHEP-4E and 4EE rate calculations. The following amounts are subtracted from each hospital's gross aggregate dollar amount: The cost of actual 1987 capital, physician coverage, and the amount included for medical education. The 1987 reimbursable operating costs are increased by a factor of .5% to provide funding for advances in medical technology, and by the 1987 through 1996 trend factor to reflect inflation, and then apportioned to inpatient and outpatient services, acute units, Medicare, and non-Medicare, using 1987 FLHEP-2 final settlement data.

The trend factors are calculated, using the Panel of Health Economists' methodology, for various groups of hospitals depending on their geographic location (upstate, downstate), urban or rural setting, and size (as measured by the number of patient days during a calendar year). This methodology is detailed in section 86-1.58 of attachment 4.19-A, Part I of the Plan. The FLHEP hospitals fall into three categories:

1. Upstate urban, less than 30,000 patient days
2. Upstate urban, greater than 30,000 patient days
3. Upstate rural, less than 15,000 patient days

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The values of the trend factors for 1996 for these three categories are provided below:

Category	1996 (Initial)
1	2.80
2	2.81
3	2.80

The initial trend factors are calculated using the latest data available; these values are subject to change as more current data become available. Consequently, the interim trend factors are adjusted up or down and these revised trend factors are then used to make prospective payment rate adjustments.

The inpatient acute, non-exempt, non-Medicare portion of each hospital's 1996 reimbursable operating costs are converted to an inpatient case payment rate for each hospital which is uniform for all of the non-Medicare payers. Each hospital's 1996 hospital specific case payment rate is blended with a group rate calculated in accordance with the State specified methodology, as detailed in section 86-1.53 of Attachment 4.19A, Part I of the Plan except that rural hospitals have the option of choosing a rate which is entirely the hospital specific rate. Each hospital's blended 1996 case payment rate will consist of two components. Forty five percent of the rate will be the hospital specific case payment rate and the remaining 55% will be the group average case payment rate. Hospitals will be grouped under the methodology described in section 86-1.54 of attachment 4.19A, Part I of the Plan.

Each hospital also receives an add-on for pass-through costs which reflect (1) the hospital's actual cost for capital; (2) the 1979 physician coverage costs trended forward in accordance with section 86-1.58 of attachment 4.19A, Part I of the Plan and adjusted for changes in physician billing practice; and (3) the amount included in the regional aggregate dollar amount in 1987 for Medical Education trended in accordance with section 86-1.58 of attachment 4.19A, Part I of the Plan.

Each hospital is paid for each inpatient discharge, which is not an outlier or exempt as defined below, on or after January 1, 1996 the hospital's blended non-Medicare case payment rate, adjusted by the Service Intensity Weight related to the discharge, plus the medical education, the physician coverage and the capital add ons.

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The hospitals shall be paid for Exempt Unit services by the payers on the same methodology and cost base as such units are paid in other hospitals in New York State. This methodology is detailed in section 86-1.57 of Attachment 4.19-A, Part I of the Plan.

Alternate Level of Care ("ALC") reimbursement is paid according to the New York State reimbursement methodology described in section 86-1.56 of Attachment 4.19-A, Part I of the Plan. The rate will be paid at the regional average nursing home per diem rate.

Hospitals transferring patients are paid a per diem rate which is calculated under the methodology detailed in section 86-1.54 of attachment 4.19-A, Part I of the Plan.

Outliers shall be paid in accordance to section 86-1.55 of Attachment 4.19-A, Part I of the Plan.

Future funding of expansion of services or facilities which require State Certificate of Need (CON) approval will occur through an adjustment determined according to State procedure and consistent with methodology described in section 86-1.61 of Attachment 4.19-A, Part I to the adjusted gross aggregate dollar amount for incremental non-volume related operating costs and adjustment to the capital add-ons when such projects are approved and implemented.

The payers participating in the contract have agreed to pay, on final settlement, their respective shares of the amount, if any, needed to assure that the hospitals receive their actual capital, and trended 1987 medical education costs and physician coverage costs.

The Health Department will certify the rates under the FLHEP-4E and 4EE Agreement for Medicaid as the rates for each hospital, contingent upon approval by HCFA of the Title XIX State Plan Amendment providing for reimbursement pursuant to this methodology.

The participating hospitals will each contribute to an administration and research fund which will be used for administrative costs of the program, data base development, to support programs designed to increase efficiency, and the severity study. The data base will include sufficient data to assign a severity measure to each case, and will allow for a statistical analysis of the changes in severity that occur, and how severity varies across hospitals and over time.

Each hospital is required to purchase or provide through a state pool excess physician malpractice insurance pursuant to New York Law. There is no federal financial participation for these malpractice costs.

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For each year of the FLHEP-4E and 4EE contract the case payment rates are adjusted to include changes to the hospitals' adjusted gross aggregate dollar amounts for capital and non-volume related costs of approved CON projects and to reflect inflation by means of a trend factor adjustment. The per diems are similarly adjusted. Capital, medical education and physician coverage cost add-ons are adjusted to reflect actual and trended 1987 costs and payments, respectively.

#### Adjusting the Case Mix Penalty for Severity Increase

The purpose of this material is to describe the method of calculating the increase in severity of illness using the Systemetrics Staging Measure, and then applying that increase as an offset against the creep component of the case mix penalty which is detailed in section 86-1.61 and 86-1.75 of Attachment 4.19A, Part I of the Plan. This offset began to be applied within the FLHEP-3 contract starting in 1989. The base year for the measurement of severity is 1987, the same base year as was used for the rate calculations in the FLHEP-3 contract.

The Finger Lakes area hospitals are currently being paid on the basis of the DRG assigned to each patient. The disease staging (Q scale) software program produces two outputs on severity; one written DRG and another relating to overall severity. The severity measure will be used as an offset to the case mix penalty which is applied if the criteria stipulated in section 86-1.75 of attachment 4.19A, Part I of the Plan are met.

The offset shall only be applied if the severity increase is positive, and the offset shall not exceed the amount of the creep component of the case mix penalty calculated by OHSM, i.e., the offset shall not turn the creep component of the case mix penalty to a positive adjustment.

#### Calculation of the Severity Increase

The change in severity is calculated for each FLAHC hospital from 1987 to the rate year (1989 and subsequent years). The methodology used to calculate this severity increase is described in the following paragraph.

Calculate the average aggregate severity of all the non-Medicare cases in the base year and in the rate year, T(b) and T(r) respectively. Calculate the average DRG weight for these cases, W(b) and W(r). The average severity in the base year is then  $T(b)/W(b)=S(b)$  and the average severity in the rate year is  $T(r)/W(r)=S(r)$ . Then the percentage increase in severity is

$$100 \times ( S(r)/S(b) - 1 ).$$

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If this increase in severity is positive, then it shall be used as an offset to the creep component of the case mix penalty to be applied for the year. If the creep component of the case mix penalty calculated by OHSM is P ( as a percentage), and the percentage increase in severity is Q, then the case mix penalty shall be reduced to P - Q, but not to less than zero.

An example of the severity offsets calculation is illustrated in Attachment A. This reduction shall be applied to the case mix penalty for 1989 and for subsequent years of the FLHEP.

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95-02

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JAN - 1 1996

Amendment providing for reimbursement pursuant to this methodology.

The participating hospitals will each contribute to an administration and research fund which will be used for administrative costs of the program, data base development, to support programs designed to increase efficiency, and the severity study. The data base will include sufficient data to assign a severity measure to each case, and will allow for a statistical analysis of the changes in severity that occur, and how severity varies across hospitals and over time.

For each year of the FLHEP-4 contract after 1991, the case payment rates are adjusted to include changes to the hospitals' adjusted gross aggregate dollar amounts for capital and non-volume related costs of approved CON projects and to reflect inflation by means of a trend factor adjustment. The per diems are similarly adjusted. Capital, medical education and physician coverage cost add-ons are adjusted to reflect actual and trended 1987 costs and payments, respectively.

The term of the FLHEP-4 Agreement is January 1, 1991 through December 31, 1993. The term of the FLHEP-4E Agreement will be January 1 through December 31, 1994.

94-03

Supplement (A-2)

MAR 15 1990

JAN 1 1994

Severity Adjustment Measurement System

The Medicare program, New York State and other states and payors, have been using the Diagnosis Related Groups (DRGs) for payment purposes. While the DRGs are reasonably homogeneous in regard to resource use, they are far from ideal, and they may not take adequate account of the severity of illness of patients. A number of adjustments have been included in payment systems to partly remedy this problem. For example, the indirect medical education adjustment in the Medicare Prospective Payment System, and the disproportionate share adjustment, are added to partly to deal with this problem. A better way to deal with the problem may be to measure severity of illness within the DRG and adjust for it directly. The purpose of the severity study that is being undertaken by FLAHC is to incorporate a severity measure to obtain a better understanding of the operation of the health care system, e.g., are patients who are travelling to obtain services in urban hospitals doing so because they are more severely ill, or for some other reason?

This study will be funded through hospital payments made to a Statewide Pool for which there is no federal financial participation. Medicaid moneys will be used to pay for inpatient hospital services.

The purpose of this demonstration is to develop a payment

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New

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system which incorporates a measure of the severity of illness of the patient into the determination of the appropriate payment rate, to show that it is feasible to implement such a system in a group of rural hospitals, and to carry out some research on the variation in severity over time, across payor classes, across hospitals, and between cases treated in the area and cases treated outside of the area.

After considerable discussion, review of the literature, and presentations from several of the severity system vendors, Disease Staging (Q-scale), which is distributed by Systemetrics, was chosen to support the development of the severity adjustment payment system. The FLAHC hospitals are currently being paid on the basis of the DRG assigned to each patient. The Disease Staging software program produces two outputs on severity level--one within the DRG and one overall--which could be useful in refining the DRGs in a payment demonstration. After discussions with the Office of Health Systems Management, it was decided that the severity measure would not be used to adjust payment rates directly, but would be used as an offset to the case mix limit that is applied if the case mix of the hospital and the State as a whole increase above certain thresholds. The case mix limit for 1989 and subsequent years is to be offset by an increase in case mix severity within the hospitals participating in the demonstration.

94-03 approved MAR 15 1990  
Supervisor New effective JAN 1 1994

Adjusting the Case Mix Penalty for Severity Increase

The purpose of this material is to describe the method of calculating the increase in severity of illness using the Systemetrics Staging Measure, and then applying that increase as an offset against the creep component of the case mix penalty applied under the FLHEP contract. This offset began to be applied within the FLHEP-3 contract starting in 1989. The base year for the measurement of severity is 1987, the same base year as was used for the rate calculations in the FLHEP-3 contract.

The offset shall only be applied if the severity increase is positive, and the offset shall not exceed the amount of the creep component of the case mix penalty calculated by OHSM, i.e., the offset shall not turn the creep component of the case mix penalty to a positive adjustment.

Calculation of the Severity Increase

The change in severity is calculated for each FLAHC hospital from 1987 to the rate year (1989 and subsequent years). There are two ways in which the increase in severity can be calculated:

1. Calculate the average within DRG severity for the base year (1987) and for the rate year (1989 or a subsequent year).

This is the weighted average severity per case, with the

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weighing being the DRG weight for the case.

$$\frac{\text{SUM} ( s(i) \times w(i) )}{\text{SUM} ( w(i) )} = S$$

Where  $s(i)$  is the DRG severity of case  $i$ ,  $w(i)$  is the DRG weight of case  $i$ , and the sum is taken over all non-Medicare cases  $i$ .

Let  $S(b)$  be the severity in the base year, and  $S(r)$  be the severity in the rate year. Then the percentage increase in severity is  $100 \times ( S(r)/S(b) - 1 )$ .

2. Calculate the average aggregate severity of all the non-Medicare cases in the base year and in the rate year,  $T(b)$  and  $T(r)$  respectively. Calculate the average DRG weight for these cases,  $W(b)$  and  $W(r)$ . The average severity in the base year is then  $T(b)/W(b)=S(b)$  and the average severity in the rate year is  $T(r)/W(r)=S(r)$ . Then the percentage increase in severity is:

$$100 \times ( S(r)/S(b) - 1 ) .$$

Method 2 is the more precise, therefore it is the one that should be offset against the case mix penalty.

94-03

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If this increase in severity is positive then it shall be used as an offset to the creep component of the case mix penalty to be applied for the year. If the creep component of the case mix penalty calculated by OHSM is P ( as a percentage), and the percentage increase in severity is Q, then the case mix penalty shall be reduced to P - Q, but not to less than zero.

This reduction shall be applied to the case mix penalty for 1989 and for subsequent years of the FLHEP.

Future analyses are planned to determine how severity changes over time within individual hospitals, how stable the measures of severity are, whether the patients who are migrating to urban providers are doing so because they are more severely ill, and other studies that will enable the hospitals to obtain a better understanding of the needs of their patients. For example, a study may be performed to determine whether patients are being admitted to a hospital at an appropriate point in the course of their illness. Admission at too early a stage when treatment could equally well be performed on an ambulatory basis could indicate inappropriate resource use, while admission at too late a stage may result in higher resource use because the patients are more severely ill than they would be if they had been admitted at an earlier stage. The hospitals may also start to use the severity system to augment their utilization review function within the hospital.

94-03

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**New** effective JAN 1 1994

## Attachment A

The following are the major components of the trend factor methodology as adopted by the Panel of Health Economists.

Projection Methodologies

Salaries. In order to quantify the salary price movement component of the trend factor, four national salary proxies are used, adjusted by a Regional Adjustment Factor (RAF). The four salary proxies are the Collective Bargaining Agreements (Nonmanufacturing), Employment Cost Index - Private Industry Workers, Employment Cost Index - Managers and Administrators, and Employment Cost Index - Professional and Technical Workers. These four proxies are weighted to produce a composite salary price movement. (Separate weightings are used for teaching and non-teaching hospitals and the Health and Hospitals Corporation.) In calculating the initial trend factors for a given year, a projection methodology for salary price movements is used. The projections are based on the compounding of quarterly increases in the salary proxies for the four latest available quarters of data. The final trend factor calculations are based on actual proxy data for the trend factor year compared to the preceding year.

Fringe Benefits. The trend factor methodology uses a Total Compensation Factor (TCF) that measures the relationship between increases in total compensation (i.e., salaries and fringe benefits) and increases in salaries. This factor is then applied to the composite salary price movement to yield a total compensation price movement, hence reflecting the fringe benefits. Two national proxies are used to determine the total compensation factor: Employment Cost Index - Total Compensation - Private Industry Workers, divided by Employment Cost Index - Wages and Salaries - Private Industry Workers. In calculating the initial trend factors for a given year, the TCF is projected based on the latest four quarters data on these two proxies. For the final trend factor calculation, actual data are used

Labor. The labor portion of the trend factor refers to the combined salary and fringe benefits components. Hence, the labor price movement is the salary price movement, adjusted by the Total Compensation Factor (TCF) and by the Regional Adjustment Factor (RAF).

Non-labor. A number of different proxies are used to measure price movements in non-labor related expenses incurred by hospitals. In calculating the initial trend factors, an estimate of the non-labor component of the trend factor is made by using the projected Gross National Product Implicit Price Deflator as published by the American Statistical Association and National Bureau of Economic Research, Business Outlook Survey. The final trend factor calculations are made using the actual changes in the non-labor proxies.

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New York

Attachment 4.19-A

Part IV

Page A1

Additional Disproportionate Share Payment

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below and are made in addition to, and not as a substitute for, the disproportionate share payment described in sections 86-1.65, 86-1.74 and 86-1.84 of Part I. However, the calculations of hospitals' bad debt and charity care experience used to determine the disproportionate share payments made under sections 86-1.65, 86-1.74 and 86-1.84 of Part I does not include the costs of services to any person for whom an additional disproportionate share payment has been made under this section.

These additional payment adjustments are made either by the Department or through an intermediary to disproportionate share hospitals ~~whowhich~~ which have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital, or an intermediary making a payment to a hospital, will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

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New York

Attachment 4.19-A  
Part IV  
Page A2

A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above, and meets the requirements of State Plan Amendment 94-26. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments either from the State directly, or through an intermediary, to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process, or intermediary payment process, and according to established rates or fees, for fee-for-service program services or by the intermediary for its services. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department, or the intermediary, as appropriate.

Disproportionate share payments under this plan cannot exceed the State disproportionate share allotment calculated in accordance with the provision of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (P.L. 102-234), as set forth at 42 CFR Sections 447.296 through 447.299, and cannot exceed the facility specific disproportionate share payment limits required by the Omnibus Budget Reconciliation Act of 1993.

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## Attachment B

**Examples of the Application of the Severity Offset to the Case Mix Penalty**

The FLHEP-4E and 4EE contracts specify that any increase in severity, on an individual hospital basis, will be offset against the creep component of the case mix penalty.

Suppose that the case mix penalty for a given FLAHC hospital for 1992 was 2%. Once the severity data for 1992 has been analyzed, the increase in severity from 1987 to 1992 will be used to reduce this case mix penalty. Three different examples are described below to illustrate the three situations which can arise in the relationship between the case mix penalty and the change in severity.

1. Suppose that the severity of illness of the discharges from the hospital increases by 0.5% from 1987 to 1992. Then the case mix penalty will be reduced by the 0.5% to 1.5%:

$$2.0\% - 0.5\% = 1.5\%$$

2. Suppose the severity of illness increases by 3% from 1987 to 1992. Then the case mix penalty will be reduced to 0%, since the increase in severity is greater than the case mix penalty.

$$2.0\% - 3.0\% = -1.0\%$$

Since this is negative the case mix penalty is set at zero.

3. Suppose the severity change from 1987 to 1992 is negative. Then there is no adjustment to the case mix penalty.

$$2.0\% - 0\% = 2.0\%$$

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Supersedes 95-02

Approved by \_\_\_\_\_ AUG 3 1999

Signature: \_\_\_\_\_ Date: JAN - 1 1998

HOSPITAL EXPERIMENTAL PAYMENT PROGRAM - (1988-1990)  
TITLE XIX (MEDICAID) STATE PLAN AMENDMENT

88

9

This State Plan amendment is contingent upon an approved contract among the HEP participating hospitals, the Rochester Area Hospitals' Corporation (RAHC), and the contracting payors.

Effective January 1, 1988, Medicaid hospital inpatient reimbursement for all HEP-III participating hospitals will be through a DRG-based case payment methodology similar to the case payment methodology for the rest of the State. However, the Medicaid case payment rates for the HEP-III participating hospitals will be based on their 1987 HEP-E payment bases (which were the original 1978 HEP cost bases trended forward and adjusted). The 1987 total payment base for each hospital is allocated to non-Medicare patients using 1987 utilization data and then trended to 1988 by an inflation factor. The non-Medicare inpatient acute portion of each hospital's 1988 payment base is then converted to an inpatient Medicaid case payment rate for each DRG. There is a blending of the hospital specific case payment rate and a group pricing component, in proportions identical to those followed by hospitals in the rest of the State. Medicaid Alternate Level of Care (ALC) patients will be reimbursed at the regional nursing home per diem rate, according to the same methodology as under the State's overall system.

Whereas, in most respects, the Medicaid inpatient reimbursement methodology in the proposed HEP-III system is the same as that for the rest of the hospitals in the State, there are unique features of the system. The chief of these is the development (in 1988) and implementation (in 1989 and 1990) of a completely new system to provide financial incentives for quality patient care which may be able to be used in the future on a wider scale if its feasibility is demonstrated among the HEP-III hospitals. The quality assurance system will use the MEDISGRPS severity classification system and develop standards against which each hospital's inpatient care will be assessed. The hospital will face financial incentives (within limitations) to assure that these standards are met.

The HEP-III hospitals will also continue to pool capital costs, medical education and physician coverage costs (through the concept of levelling).

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Methods and Standards for Establishing Payment Rates

Out of State Services

I. Inpatient Hospital Care

New York ~~reimburse's~~reimburses out of state hospitals at the facility's Medicaid rate established by the State in which the institution is located; or when no such rate exists, at the lowest of the following charges:

1. the Medicare rate set for the hospital; or
2. the hospital's customary charge for public beneficiaries; or
3. the maximum New York State Title XIX rate for similar inpatient care.

Reimbursement for those days where recipients are awaiting placement to an alternate level of care (ALC) while they are inpatients at out of state hospitals will be at the facility's approved Medicaid ALC rate.

II. Additional Disproportionate Share Payment

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below.

These additional payment adjustments are made either by the Department or through an intermediary to disproportionate share hospitals ~~whewhich~~ which have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

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Each hospital, or an intermediary making a payment to a hospital, will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above, and meets the requirements of State Plan Amendment 94-26. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments either from the State directly, or through an intermediary, to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process, or intermediary payment process, and according to established rates or fees, for fee-for-service program services or by the intermediary for its services. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department, or the intermediary, as appropriate.

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## Rate Setting and Financial Reporting

- (a) For the purpose of this section, the following definitions shall apply:
- (1) Specialty Hospital or "Facility" shall mean that program and site for which OMRDD has issued an operating certificate, pursuant to Mental Hygiene Law Article 16, to operate as a Specialty Hospital, and for which the New York State Department of Social Services has issued a Medicaid provider agreement[.] and which is subject to the special rule described in section 1923(e) of the Social Security Act.
  - (2) "Provider" shall mean the individual, corporation, partnership or other organization to which the OMRDD has issued an operating certificate, pursuant to Mental Hygiene Law Article 16, to operate a Specialty Hospital, and to which the New York State Department of Social Services has issued a Medicaid provider agreement for such facility.
  - (3) "Alternate Care Determined Client" or "ACD Client" shall mean a client who has been determined not to require specialty hospital care after completion of an independent utilization review, pursuant to 14 NYCRR Section 680.9.
  - (4) A "newly certified facility" shall mean a facility which has been in operation less than two years and has not yet submitted a cost report which covers a full 12 months of operation for any rate period January 1 to December 31 or any other 12-month period designated by the commissioner according to Section (b)(1)(ii)(b).
  - (5) "Actual cost" shall mean the costs that were audited and stepped-down by OMRDD or its agent for the specialty hospital and which are taken from the financial reports filed annually in accordance with Section (b)(1)(ii) and which cover a full 12-month period of operation beginning 24 months prior to the effective date of the rate period in question. For the rate period from June 10, 1988 to December 31, 1988, as stated in Section (d)(3), the actual costs defined in the preceding sentence shall be taken from the annual financial information filed by the provider for the calendar year 1985 with Blue Cross/Blue Shield of Greater New York.

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- (6) Budget costs shall mean the financial information submitted by a provider in accordance with section(b) (1) (i).
- (7) Reimbursable costs shall mean those actual or budget costs which are determined, based on a line item review/desk audit process by Office of Mental Retardation and Developmental Disabilities or Blue Cross/Blue Shield of Greater New York, to be allowable in accordance with section(d) (8).
- (8) "Operating costs" shall mean a facility's costs, other than capital costs or start-up costs, which include personal service costs, administrative and general services costs, and other than personal service (OTPS) costs. Where applicable, operating costs must be in accordance with subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, in the ICF/DD portion of this Plan, and subdivision (k) Glossary, also in the ICF/DD portion of this Plan.
  - (i) Personal service costs include costs such as salaries, fringe benefits and accrued vacation costs for employees of the specialty hospital; and costs of persons performing services under contract to the specialty hospital. Services refers to the provisions of routine and ancillary care of clients admitted to the specialty hospital in accordance with the provisions of this Part.
  - (ii) Administrative and general service costs refer to departments, divisions or other units which are operated for the benefit of the specialty hospital as a whole, and includes activities such as management, housekeeping, laundry, dietary services and operation and maintenance of grounds and physical plant.
  - (iii) OTPS costs include, but are not limited to, the costs of items such as food, minor equipment, supplies and materials, travel, medications and utilities.
- (9) Capital costs shall mean property costs in accordance with subdivision (i) General Rules for Capital Costs and Costs of Related Party Transactions, in the ICF/DD portion of this Plan, and subdivision (k) Glossary, also in the ICF/DD portion of this Plan. (subject to the limitations contained in this section and allowance for depreciation and interest on capital assets according to Medicare principles of reimbursement.)

(b) Reporting requirements.

- (1) Financial reports shall include the following:
  - (i) Budget reports
    - (a) Each provider intending to operate a specialty hospital shall include budget reports in its application to receive an operating certificate.

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(b) The budget report shall cover a 12-month period from January 1 to December 31 unless another time frame is specified by the commissioner.

(c) If a facility has undergone a change in its site specific certified capacity, the commissioner may, at his discretion, request the provider to submit a budget report subject to requirements listed in subsection (b) (1) (i) (b) and (b) (3) (iii).

(ii) Financial and Statistical Reports

(a) Each provider that operates a specialty hospital certified by OMRDD shall, on an annual basis, complete and file with the OMRDD and/or Blue Cross/Blue Shield of Greater New York, annual financial reports and related statistical information in the form and format supplied by the OMRDD and/or Blue Cross/Blue Shield of Greater New York.

(b) Such report shall cover a 12-month period from January 1 to December 31, unless another time frame is specified by the commissioner.

(c) Each such report shall be forwarded so that it is received no later than 120 days after the last day of the period which it covers, except as stated in Section (b) (4) (i) and (ii).

(d) If a facility has undergone a change in its site specific certified capacity, the commissioner may, at his discretion, request the facility to submit the incremental/decremental cost data associated with the capacity change. Such data shall comply with the requirements of Section (b) (3) (i).

(2) Statistical reporting requirements for specialty hospitals shall include but not be limited to the following:

(i) Each provider shall submit with its annual financial report, statistical data relevant to program utilization and in the form and format supplied by OMRDD or its agent, Blue Cross/Blue Shield of Greater New York. Such data shall include a roster of clients and their utilization review status for the financial reporting period in question, a listing of the actual number of client days for the specialty hospital and a

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a listing by client of the total number of days any client was on alternate care determination status as defined in section(a)(3). This data will correspond to the identical time period of the financial report.

(ii) Each provider shall, upon the request of OMRDD, submit statistical data relevant to the administration and operation of the program as determined by the commissioner. Such data shall be submitted within the time frames specified in the request.

(3) Requirements for certification of financial reports and related statistical information.

(i) Each provider shall complete the required financial reports in accordance with generally accepted accounting principles, unless other principles are specified by this subpart or the Medicare Provider Reimbursement Manual, commonly referred to as HIM-15, published by the U.S. Department of Health and Human Services Health Care Financing Administration (HCFA). The HIM-15 document is available from:

Health Care Financing Administration  
Division of Publication Management-SLL-12-15  
7500 Security Boulevard  
Baltimore, MD 21244-1850

(ii) The Medicare Provider Reimbursement Manual may be reviewed in person during regular business hours at the:

(a) NYS Department of State, 99 Washington Avenue, Albany, NY 12231; or by appointment at the

(b) NYS Office of Mental Retardation and Developmental Disabilities, Division of Revenue Management, 44 Holland Avenue,  
Albany, NY 12229-0001.

(iii) Financial reports information shall be certified for their compliance with section(b)(3)(i) by the provider's executive director or officer and by an independent licensed public accountant or certified public accountant who is not on the staff of the provider, on the staff of a program operated by the provider, and who has no financial interest in the provider nor is  
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affiliate in the program operated by the provider;] a related party as defined in subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions in the ICF/DD portion of this Plan, and(k) Glossary, also in the ICF/DD portion of this Plan; and include a statement of the findings and opinion of the certified public accountant or licensed public accountant.

- (iv) Budget reports shall be certified for their fair representation of anticipated expenditures by the provider's executive director or officer.
- (4) Failure to file required financial and statistical reports.
- (i) The commissioner may grant an extension of time of up to 30 days for filing the required reports if OMRDD receives a written request for an extension from a provider, at least 15 days prior to the initial due date. Such request for extension shall document in writing that the provider cannot file the report by the due date for reasons beyond its control, and shall include an explanation of such reasons.
  - (ii) The commissioner may grant an additional extension of 30 days if the provider applies for an extension in accordance with the procedure stated in section(b) (4) (i) above. The maximum allowable extension that may be granted will not exceed 60 days in total unless the commissioner, upon investigation, finds that failure to report is beyond the control of the provider and/or enforcement of the reporting time frame requirements would jeopardize the program's operation.
  - (iii) If a provider fails to file the required reports, on or before the due dates, taking into account any granted extensions, the commissioner may, at his or her discretion, reduce the specialty hospital's existing rate, exclusive of State-paid items, by five percent for a period beginning on the first day of the month following the due date of the required reports and continuing until the last day of the calendar month in which the required information is received.
  - (iv) In the event that the rate for a specific rate period cannot be developed so that it will be effective on the first day of the rate period, due to the facility's not submitting the required reports by the due date, the rate in existence on the last day of the rate period (i.e., the length of time as determined by the commissioner that an approved rate is valid) prior to the subject rate period, will be in effect until such

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time as OMRDD can develop a new rate. The rate in existence on the last day of the rate period may be reduced by five percent according to the provisions of section(b) (4) (iii).

(v) When OMRDD develops a new rate for a specialty hospital for which a rate was paid in accordance with section(b) (4) (iv) above, the rate developed will be effective on the first day of the first month following receipt of the required reports. The commissioner may, at his discretion and based upon his finding that the factor(s) causing the delay has/have been corrected, make the rate retroactive to the beginning of the rate period in question if the provider makes such a request within 60 days subsequent to submission of the delinquent report.

(5) Requirements for the revision of financial reports shall include the following:

(i) In the event that OMRDD determines that the required financial report is incomplete, inaccurate, incorrect or otherwise unacceptable, the provider shall have 30 days from the date of its receipt of notification to submit revised financial reports or additional data. Such data or reports shall be certified by the provider's executive director or officer and an independent licensed public accountant or certified public accountant pursuant to the requirements stipulated in section(b) (3).

(ii) If the revised data referred to in section(b) (5) (i) is not received within 30 days of the provider's receipt of notification, the facility's existing rate may be reduced in accordance with section(b) (4) (iii) unless the commissioner has granted an extension pursuant to section(b) (4) (i) or (ii).

(iii) In the event the provider discovers that the financial reports it has submitted are incomplete, inaccurate, or incorrect prior to receiving its new rate, the provider must notify OMRDD that such error exists. The provider will have 30 days from the date such notification is received by OMRDD to submit revised reports or additional data. Such data or report shall meet the certification requirements of the report being corrected. If the corrected data or report is received within a reasonable time before the issuance of the

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rate, OMRDD shall incorporate the corrected data or report into its computation of the rate without the provider having to file an appeal application.

- (iv) If the revised data or report referred to in section(b)(5)(iii) is not received within the time periods set forth in section(b)(5)(iii) above, the facility's existing rate may be reduced in accordance with section(b)(4)(iii).

(c) Requirements of Financial Records

- (1) Each provider shall maintain financial records which reflect all expenditures made and revenues received for its operations.
- (2) Each provider shall complete and file with the New York State Department of Health and/or its agent, annual financial and statistical report forms supplied by the New York State Department of Health and/or its agent.
- (3) The financial records shall include separate accounts for each type of expense and revenue included on the annual budget or annual cost report. Such sub-accounts and control accounts as are necessary for effective financial management may be established by the specialty hospital. A separate expense and revenue account shall be established to properly identify the expense and revenues directly and indirectly attributable to ACD clients.
- (4) All such financial records and any related records shall be subject to audit by the commissioner or his agent, the Office of the State Comptroller, the State Department of Social Services and by agencies of the federal government as provided by law.

(d) Rate Setting

- (1) A client day shall be the unit of measure denoting lodging and services rendered to one client between the census taking hours of the facility on two successive days; the day of admission but not the day of discharge shall be counted. One client day shall be counted if the client is discharged on the same day that the client is admitted, providing that there was an expectation that the admission would have at least a 24-hour duration.

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(2) For each facility the commissioner shall have established rates of reimbursement which are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities in order to provide care and service in conformity with applicable State and federal laws, regulations, and quality and safety standards.

(3) The rate period shall be from June 10, 1988 to December 31, 1988. Beginning January 1, 1989 and every year thereafter, the rate period shall be from January 1 to December 31.

(4) Rate calculation.

(i) The rate for all non-ACD clients, and for ACD clients when the commissioner has determined that the occupancy of certified beds for the facility and the region is 80 percent or more (beds occupied by ACD clients shall not be counted as occupied beds), shall be determined as follows:

(a) For a newly certified facility, or any facility which has undergone a change of 10 percent or more in its site-specific certified capacity and for which the commissioner has exercised his or her discretion according to section 680.12 (b) (1) (i) (c) of this Part, the reimbursable budget costs shall be divided by the higher of actual projected client days or calculated projected client days. Calculated projected client days shall be determined by multiplying the certified capacity, as listed on the provider agreement of the facility, by 365 days and by a utilization factor of 95 percent.

(b) For a facility other than the facilities covered in clause (a) of this subparagraph, the reimbursable actual costs shall be first trended to the rate year and then divided by the higher of either the actual reported client days, or the product of the certified capacity, as listed on the provider agreement, multiplied by 365 days and a utilization factor of 95 percent. The trend factor utilized shall be that figure developed by the New York State Office of Mental Retardation and Developmental Disabilities [Health Systems Management based upon the price movement for voluntary operated, nonteaching hospitals located in New York City.]

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- (ii) For any ACD client, when the commissioner has determined that the occupancy of certified beds for the facility and the region is less than 80 percent (beds occupied by ACD clients shall not be counted as occupied beds) and when the provider has demonstrated in accordance with its utilization review plan as required by section 680.9 that no alternate care bed at the appropriate level is available, the rate shall be the average payment rate of all intermediate care facilities for the developmentally disabled (ICF/DDs). The average payment rate shall be the statewide average ICF/DD rate as of July 1, prior to the rate period in question.
- (a) Reimbursement of an all-inclusive, 24-hour ICF/DD rate will be decreased by the day program component of the ICF/DD rate for those ACD clients who attend an outside day program and for which separate day program reimbursement has been sought or is provided.
- (b) The specialty hospital shall be responsible for ensuring that no duplicate billing for day program services occurs.
- (c) The actual level of care provided for ACD clients shall be in accordance with the recommendations of an OMRDD-approved utilization review team and delivered pursuant to the regulations applicable to the recommended level of care.

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(iii) There shall be no reimbursement for the following ACD clients:

(a) Those for whom the provider has not made the required showing with respect to an appropriate alternate care bed in accordance with its utilization review plan as required by section 680.9. An exception may be made if the provider has taken steps to transfer a client to an appropriate alternate care bed and a challenge as allowed in regulation has been made on behalf of the client.

(b) Those for whom the alternate care determination does not indicate that a Medicaid funded program is the appropriate level of care.

(5) Total reimbursable budget or actual operating costs utilized to calculate a rate shall be subject to [base-to-base] cost limitation principles as follows:

(i) Newly certified facilities

(a) Year 1 - Provider submits a budget. Rate is established from reimbursable budget costs and projected client days in accordance with section (d)(4)(i)(a).

(b) Year 2 - Year 1 reimbursable operating costs of the budget rate are trended with property costs added after trending.

(c) Year 3 - Rate is established as the lower of either:

(1) The reimbursable operating component of the actual costs, as defined in section (a)(5), for the Year 3 rate period trended to the rate period with the property costs added after trending, or

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- (2) The Year 2 rate, excluding property, trended with the property costs from the latest full year cost report added after trending.
- (d) Year 4 - Rate is established as the lower of either:
  - (1) The reimbursable operating component of the actual costs, as defined in section (a)(5) for the Year 4 rate period trended to the rate period with the property costs added after trending, or
  - (2) The Year 3 rate, excluding property, trended with the property costs from the latest full year cost report added after trending.
- (ii) Other than newly certified facilities
  - (a) Year 1 - Provider submits actual costs as defined in section (a)(5). A rate is established by trending the reimbursable operating costs and adding the property costs after trending.
  - (b) Year 2 - Rate is established as the lower of either:
    - (1) The reimbursable operating component of the actual cost, as defined in section (a)(5), for the Year 2 rate period trended to the rate period with the property costs added after trending, or
    - (2) The Year 1 rate excluding property, trended with the property costs from the latest full year cost report added after trending.
  - (c) Year 3 - Rate is established as the lower of either:
    - (1) The reimbursable operating component of the actual cost, as defined in section (a)(5), for the Year 3 rate period trended to the rate period with the property costs added after trending, or
    - (2) The Year 2 rate, excluding property, trended with the property costs from the latest full year cost report added after trending.

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- (d) Year 4-rate is established as the lower of either:
- (1) the reimbursable operating component of the actual cost, as defined in section (a) (5), for the Year 4 rate period with the property costs added after trending; or
  - (2) the Year 3 rate, excluding property, trended with the property costs from the latest full-year cost report added after trending.
- (e) The rate shall be equal to the reimbursable operating costs and appropriate appeal adjustments contained in the Year 4 rate calculated pursuant to 5(i) (d) and trended in accordance with Section (d) (4) (i) (b) of this Part. Appropriately approved property shall be added to this amount.
- (6) Payments attributable to a newly admitted client are subject to the commissioner's approval of that client's admission pursuant to section (b). Continued payments for each such client are subject to the facility's having obtained the approval of the commissioner on an annual basis for the retention of that client at the specialty hospital level of care.
- (7) Reimbursement offsets.  
If the costs of services not chargeable to the care of clients in accordance with 14 NYCRR as stated herein or HIM-15 are indeterminable and there is revenue derived therefrom, this revenue shall offset allowable cost.
- (8) To be considered allowable, costs must be properly chargeable to necessary client care rendered in accordance with the requirements contained herein
- (9) To be considered allowable, costs must be in accordance with subdivision (i) General Rules for Capital Costs and Costs of Related Party Transactions, in the ICF/DD portion of this Plan, and subdivision (k) Glossary, also in the ICF/DD portion of this Plan.

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(i) Except where specific rules concerning allowability of costs are stated herein, or in subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions in the ICF/DD portion of this Plan, and subdivision (k) Glossary, also in the ICF/DD portion of this Plan. OMRDD shall use as its major determining factor in deciding on the allowability of costs, the Medicare Provider Reimbursement Manual (HIM-15).

(See section(b) (3) (i) .) Where specific rules stated herein or in HIM-15 are silent concerning the allowability of costs, the commissioner shall determine allowability of costs based on reasonableness and relationship to client care and generally accepted accounting principles.

(ii) A monetary value assigned to services provided by a religious order and for services rendered by an owner and operator of a facility shall be considered allowable subject to review by OMRDD for reasonableness.

(iii) As determined by the commissioner, expenses or portions of expenses reported by an individual facility that are not reasonably related to the efficient and economical provision of care in accordance with the requirements contained herein because of either the nature or amount of the item, shall not be allowed.

(iv) As determined by the commissioner, costs which principally afford diversion, entertainment or amusement to owners, operators or employees of the facility shall not be allowed.

(v) As determined by the commissioner, costs for any interest expense related to funding expenses in excess of a facility's approved reimbursement rate, except as provided for in section (d) [(8)] (2) (xi), or for any penalty imposed by governmental agencies or courts or for the costs of insurance policies obtained solely to insure against such penalty shall not be allowed. OMRDD will not pay interest on the final dollar settlement resulting from the retrospective impact of rate appeals. OMRDD will not reimburse interest expense incurred to meet funded depreciation requirements, pursuant to section(d) [(10)] (2).

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(vi) Costs of contributions or other payments to political parties, candidates or organizations shall not be allowed.

(vii) As determined by the commissioner, only that portion of the dues paid to any professional association which has been demonstrated to be attributable to expenditures other than for lobbying or political contributions shall be allowed.

[(viii) Except as limited below, any reasonable cost incidental to and including the cost of the sale, purchase, alteration, construction, rehabilitation and/or renovation of a physical plant shall be considered allowable up to the amount approved by the commissioner and the director of the Division of the Budget.]

(viii)(a) For any transaction resulting in a change of ownership, the valuation of the asset(s) shall be limited to the lesser of the allowable acquisition cost of the asset(s) to the first owner of record who has received Medicaid payment for the asset(s) in question on or after July 18, 1984, minus any paid depreciation (i.e., seller's net book value) or the acquisition cost of the asset to the new owner.

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(b) Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under Medicaid, shall not be allowable for reimbursement.

(c) If a facility's real property assets are sold or leased, or subject to any other transaction which results in a net decrease in the real property cost to the provider, the real property cost portion of a facility's rate shall be prorated accordingly. For the purpose of this section, real property assets refers to buildings, building improvements and fixed equipment. Real property costs are the costs directly related to real property assets.

(ix) A facility's annual rental payments for real property may be considered an allowable cost subject to the following conditions:

(a) The lease is reviewed by and acceptable to Office of Mental Retardation and Developmental Disabilities and any other State agency which must by law or regulation review and approve reimbursement rates

(b) The lease agreement must be considered an arm's-length transaction not involving either an affiliate controlling person, immediate family or principal stockholder

(c) The arm's-length transaction requirement may be waived by the commissioner upon application for those corporations holding title to the specialty hospital's physical plant, created pursuant to the Not-for-Profit Corporation Law with the approval of the commissioner.

(d) For the purposes of this section, affiliate means:

- (1) With respect to a partnership, each partner thereof.
- (2) With respect to a corporation, each officer, director, principal stockholder and controlling person thereof.

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- (d) With respect to a natural person, each member of said person's immediate family or each partnership and each partner of such person or each corporation in which said person or any affiliate of said person is an officer, director, principal stockholder or controlling person.
- (e) For the purposes of this section, controlling person of any corporation, partnership or other entity means any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interest, to direct or exert a controlling influence on the direction of the management policies of said corporation, partnership or other entity. Neither the commissioner, nor any employee of the OMRDD, nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a facility, shall by reason of his or her official position be deemed a controlling person of any corporation, partnership or other entity. Nor shall any person who serves as an executive director, officer, administrator, principal employee or other employe of any corporation, partnership or other entity or as a member of a board of directors or trustees of any corporation be deemed to be a controlling person of such corporation, partnership or other entity solely as a result of of such position or his or her official actions in such position.
- (f) For the purposes of this section, immediate family means brother, sister, grandparent, grandchild, first cousin, aunt or uncle, spouse, parent or child of such person whether such relationship arises by reason of birth, marriage or adoption.
- (g) For the purposes of this section, principal stockholder of a corporation means any person who beneficially owns, holds or has the power to vote, 10 percent or more of any class of securities issued by said corporation.
- (h) The rental amount is comparable to similar leases for properties with similar functions in the same geographic area.

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- (i) If the above criteria are not met, reimbursement for lease costs will be determined in accordance with section(d) (8) (x) and (xii).
- (j) Lease options to renew shall not be exercised without review and approval of the parties listed in section (d) (8) (ix) (a). Such review and decision shall occur whenever possible more than 30 days before the last date the option may be exercised, the date of which the facility has notified OMRDD in accordance with section(d) (8) (ix) (k).
- (k) Request for approval of lease renewals shall be submitted whenever possible at least 120 days prior to the last date for the exercise of the lease renewal option.
- (x) Depreciation shall be an allowable cost when based upon factors of historical costs and useful life of buildings, fixed equipment and/or capital improvements. For the purposes of this section:
  - (a) Unless an exception is made by the commissioner, the useful life shall be the higher of the reported useful life or those from the Estimated Useful Lives of Depreciable Hospital Assets (1983 edition) published by the American Hospital Association and available by writing to the American Hospital Association, 849 Lake Shore Drive, Chicago, IL 60611. On an exception basis, a useful life that is based upon historical experience as shown by documentary evidence and approved by OMRDD may be allowed.
  - (b) The depreciation method used shall be the straight-line method.
  - (c) In the event that the historical cost of the facility cannot be adequately determined by the commissioner, an appraisal value shall be the basis for depreciation. The appraisal shall produce a value approximating the cost of reproducing substantially identical assets of like type, quality and quantity at a price level in a reasonably competitive market as of the date of acquisition. Such appraisal shall be conducted by an appraiser approved by OMRDD and pursuant to a method approved by OMRDD and the cost of that appraisal is also allowable.

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Supersedes TN 88-14 Effective Date OCT 01 2000 JAN 01 2001

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- (xi) Costs related to moveable equipment, furniture and fixtures may be considered an allowable cost subject to the following:
  - (a) Depreciation based upon historical cost of moveable equipment, furniture and fixtures is considered an allowable cost. The useful life shall be the higher of the reported useful life, or those from the Estimated Useful Lives of Depreciable Hospital Assets (1983 edition), published by the American Hospital Association and available by writing to the American Hospital Association, 840 Lake Shore Drive, Chicago, IL 60611. On an exception basis, a useful life that is based upon historical experiences as shown by documentary evidence and approved by OMRDD may be allowed.
  - (b) The facility shall use the straight-line, double-declining balance or sum-of-the-year's-digits depreciation method. The depreciation method utilized must remain consistent throughout the useful life of an asset.
  - (c) Lease payments may be an allowable cost if the payments are made under a lease which is an arm's-length transaction as described in section (d) (8) (ix) (b).
  - (d) Any personal property and equipment transactions shall be through a multiple bid process and entered into at a fair market value price.
  - (e) If lease payments are not made pursuant to an arm's-length agreement, allowable costs will include allowable depreciation, the associated interest expense, if any, and other related expenses, including but not limited to maintenance costs.
- (xii) Interest cost may be considered an allowable cost subject to the following:
  - (a) Interest for capital indebtedness, where the capital indebtedness does not exceed the current Office of Mental Retardation and Developmental Disabilities approved value of the property, will be considered allowable.
  - (b) An interest rate shall not be in excess of the amount a prudent borrower would pay at the time the loan was incurred.

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- (c) The loan agreement must be entered into between parties not related through control, ownership, affiliation, or personal relationship as defined in section(d) (8) (ix) (d), unless this provision is waived by the commissioner. Such waiver shall be based on, but not limited to, a demonstration of need for the program and cost savings resulting from the transaction.
- (d) Interest income generated from the facility's revenues for the operation of the facility shall be used to offset interest expense incurred during the same reporting period.

Notwithstanding the foregoing, a facility is not required to use the following to offset interest expense: income earned on qualified pension funds, income from gifts or grants which is donor-restricted, or income earned on secure investments pursuant to section(d) (10).

- (e) Interest on working capital indebtedness in accordance with standards contained herein will be considered allowable. In the event that a loan is not in accordance with the standards listed above, the approval of the commissioner is required.

(xiii) Costs of related organizations, other than costs incurred pursuant to a lease, rent or purchase of real property, may be considered an allowable cost subject to the following:

- (a) A "related organization" means any entity of which the provider is in control or which the provider is controlled by (subject to the limitations in section (d) (8) (ix) (e), either directly or indirectly, or where a common ownership or financial interest exists in an entity which supplies goods and/or services to the facility.
- (b) The costs of goods and/or services furnished to a facility, within the course of normal business operations, by a related organization are allowable at the cost to the related organization, or the market price of comparable goods and/or services available in the facility's region, whichever is lower.]

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[(xiv)](ix) Restricted funds are funds expended by the facility which include grants, gifts, and income from endowments, whether cash or otherwise, which must be used only for a specific purpose as designated by the donor or grant instrument. Restricted funds are to be deducted from the designated costs when determining allowable costs. The commissioner may waive the provisions of this section at his discretion only in those instances where the provider makes a reasonable showing that the imposition of the requirements of this section would have a material adverse effect on the facility's capability to operate in an efficient and economical manner.

[(9)](10) All rates, and any adjustments to a facility's rates, shall not be considered final unless approved by the director of the Division of the Budget.

[(10)](11) For any rate period during which the reimbursement attributable to depreciation on a facility's real property, excluding equipment, exceeds the provider's principal repayment obligations on indebtedness attributable to such real property, such provider shall fund depreciation by depositing such difference in an interest-bearing checking account or other secure investment. If the provider operates more than one facility governed by section(d) [(10)](9), the provider may maintain one funded depreciation account for two or more facilities. The provider shall not commingle such funded depreciation account(s) with other monies of the provider. The provider shall not be required to fund depreciation attributable to the provider's equity in such real property. The provider may expend the funds in such account, including accrued interest, to retire all or a portion of the indebtedness attributable to such real property, or for building improvements and/or fixed equipment necessary to the Facility.

(e) Rate Appeals

(1) First Level Rate Appeals

The commissioner shall consider first level rate appeals applications for revisions to the rate, if brought within 120 days of the provider's receipt of the initial rate computation sheet. However, if the appeal is to the ACD rate calculated in accordance with section(d) (4) (ii), the appeal must be from the ACD rate for a group of individuals residing in a physically distinct wing, unit or part of the facility, receiving similar services, having similar characteristics, and for whom the provider can identify discrete costs.

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- (ii) For any appeal, the provider must demonstrate that the rate requested in the appeal is necessary to ensure efficient and economic operation of the facility. If an appeal pursuant to this section is to the ACD rate, the provider must also show that the clients to whom the appeal pertains require care for which the necessary cost of providing client care exceeds the ACD rate.
- (iii) First Level rate revision appeal applications shall be made in writing to the commissioner.
- (a) The application shall set forth the basis for the appeal and the issues of fact. Appropriate documentation shall accompany the application and OMRDD may request such additional documentation as it deems necessary.
- (b) Actions on first level rate appeal applications will be processed without unjustifiable delay.
- (iv) A rate revised by OMRDD pursuant to an appeal shall not be considered final unless and until [the appeal is granted by OMRDD and] approved by the State Division of the Budget.

Except as provided in item (vi) below, at the conclusion of the first level appeal process, OMRDD shall notify the Specialty Hospital of any proposed revised rate or denial of same. OMRDD shall inform the facility that the facility may either accept the proposed revised rate or request a second level appeal in accordance with Title 14 NYCRR section 602.9 in the event that the proposed revised rate fails to grant some or all of the relief requested.

[There shall be a formal notification of the final decision on the provider's rate appeal. However,] At no point in the first level appeal process shall the provider have a right to any form of interim report or determination made by OMRDD or Division of the Budget.

- [(6)] [Such formal notification shall be sent to the provider by certified mail, return receipt requested.]
- [(7)] (vi) If OMRDD approves the revision to the rate and State Division of the Budget denies the revision, the provider shall have no further right to administrative review pursuant to this section.
- [(8)] (vii) Any rate revised in accordance with section (d) shall be effective according to the dates indicated in the approval of rate appeal notification. Such notification shall be sent to the provider by certified mail, return receipt requested.
- [(9)] (viii) Any additional reimbursement received by the facility, pursuant to a rate revised in accordance with section (e), shall be restricted to the specific purpose set forth in the final appeal decision.

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Supersedes TN 88-14 Effective Date JUL 1 1991

[(10) If OMRDD denies an appeal to the rate in whole or in part, the facility shall have the right to a hearing in accordance with 14 NYCRR Part 602.]

(2) Second level rate appeals

- (i) OMRDD's denial of the first level appeal of any or all of the relief requested in the appeals provided for in this section of the State Plan shall be final, unless the facility requests a second level appeal to the commissioner in writing within 30 days of notification of denial or proposed revised rate.
- (ii) Second level appeals shall be brought and determined in accordance with the applicable provision of Title 14 NYCRR Part 602.
- (iii) A rate revised by OMRDD pursuant to a second level appeal shall not be considered final unless and until approved by the State Division of the Budget.

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Supersedes TN New Effective Date JUL 1 1991

(10) [If CHPDD denies an appeal to the rate in whole or in part, the facility shall have the right to a hearing in accordance with 14 NYCRR Part 602.]

(f) Audits

- (1) Each provider shall maintain the statistical and financial records which formed the basis of the reports submitted to the commissioner or his agent for six years from the date on which the reports were submitted or due whichever is later.
- (2) All such records shall be subject to audit for a period of six years from the date on which the reports were submitted or due to the commissioner or his agent, whichever is later.
  - (i) Field audits or desk audits shall be conducted by the commissioner or his agent or the Department of Social Services at a time and place and in a manner to be determined by the commissioner or the DSS.
  - (ii) The audits may be performed on any financial or statistical records required to be maintained.
  - (iii) Any finding of an above described audit shall constitute grounds for recoupment at the discretion of the commissioner, provided that such audit finding relates to the allowable costs, and to the extent that, except as authorized in 18 NYCRR Section 517.86, the audit finding has been upheld in a decision after a hearing or a hearing has not been requested on such finding.
  - (iv) The six-year limitation shall not apply in situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this section.
- (3) All administrative review (including hearings) of audits conducted to determine allowable Medicaid expenses and offsetting revenues shall be in accordance with 18 NYCRR Part 517.
- (4) All administrative review of audits which are conducted by CHPDD, and which are not described in section (f)(3) above, shall be in accordance with the following:

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Date JUL 1 1991

- (i) At the conclusion of the audit, the provider shall be afforded a opportunity to submit additional documentation to the commissioner. After the receipt and review of such additional documentation, a copy of the audit findings shall, within 120 days, be sent to the provider by certified mail, return receipt requested. In order to have the additional documentation considered, the provider must submit the documentation within the time specified.
- (ii) The audit findings shall become final unless within 30 days of receipt thereof, the provider requests an administrative review of the audit findings.
- (iii) Request for administrative review and audit findings shall be sent to the commissioner by registered or certified mail.
- (iv) Such requests shall contain a detailed statement of the provider's objections to the findings, along with copies of any documentation the facility wishes to submit.
- (v) The provider shall be notified in writing of the determination of those items to which the provider objected, including a statement of the reasons therefor. The audit findings, as adjusted in accordance with the determination after administrative review, shall be final.
- (g) Effective [April 16, 1992] April 4, 1996, [the amount of the provider of service assessment included in the rate is equal to eighty percent of the total assessment amount] the rate shall include 5.4 percent of the base costs used to determine the costs associated with the 6 percent provider of services assessment, a tax imposed on providers of service in accordance with Public Law 102-234, the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991. The Medicaid reimbursed portion of the provider of service assessment is limited by and correlated to the volume of Medicaid services rendered compared to the total volume of all services rendered.

TN 96-23 Approval Date SEP 22 1997  
 Supersedes TN 92-32 Effective Date APR 04 1996 APR 04 1996

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g. Additional Disproportionate Share Payment

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below.

These additional payment adjustments are made either by the Department or through an intermediary to disproportionate share hospitals which have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital, or an intermediary making a payment to a hospital, will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

TN 96-40 B Approval Date MAY 14 2001  
Supersedes TN 91-58 Effective Date SEP 26 1996

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A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above, and meets the requirements of State Plan Amendment 94-26. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments either from the State directly, or through an intermediary, to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process, or intermediary payment process, and according to established rates or fees, for fee-for-service program services or by the intermediary for its services. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department, or the intermediary, as appropriate.

Disproportionate share payments under this plan cannot exceed the State disproportionate share allotment calculated in accordance with the provision of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (P.L. 102-234), as set forth at 42 CFR Sections 447.296 through 447.299, and cannot exceed the facility specific disproportionate share payment limits required by the Omnibus Budget Reconciliation Act of 1993.

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Supersedes TN 91-58 Effective Date SEP 26 1996

N.Y.

TYPE OF SERVICE

METHOD OF REIMBURSEMENT

Rehabilitative Services

School Supportive Health Services

Physical Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Occupational Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Speech Pathology Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated

TN 92-42 Approval Date JUN 02 1995

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Rehabilitative Services  
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with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

**Nursing Services**

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.

**Psychological Counseling Services**

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.

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Psychological Evaluations

The fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Transportation Services

The transportation fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the fee.

Audiological Evaluations

The fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Medical Evaluations

The medical evaluation fee and specialized medical evaluation fee are fee-for-service and are made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee. The specialized medical evaluation fee is reimbursable only when the service is provided by a physician specialist subsequent to and upon the written recommendation of the provider of a medical evaluation.

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Rehabilitative Services  
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Preschool Supportive Health Services

Physical Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Occupational Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Speech Pathology Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated

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Rehabilitative Services  
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with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Nursing Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.

Psychological Counseling Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.

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Psychological Evaluations

The fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Transportation Services

The transportation fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the fee.

Audiological Evaluations

The fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Medical Evaluations

The medical evaluation fee and specialized medical evaluation fee are fee-for-service and are made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee. The specialized medical evaluation fee is reimbursable only when the service is provided by a physician specialist subsequent to and upon the written recommendation of the provider of a medical evaluation.

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Type of Service

Case Management Services  
Target Group B:

Persons enrolled in Medical Assistance who:

- (1) Have a documented diagnosis of mental retardation or a developmental disability as defined in New York Mental Hygiene Law §1.03, and
- (2) Are in need of ongoing comprehensive service coordination rather than incidental service coordination, and
- (3) Have chosen to receive the services, and
- (4) Do not reside in intermediate care facilities for the developmentally disabled; State operated developmental centers; small residential unit (SRU); nursing facilities, or hospitals or any other medical assistance institutional settings that provide service coordination, and
- (5) Are not concurrently enrolled in any other comprehensive service coordination service funded under Medical Assistance.

**METHOD OF REIMBURSEMENT**

The method of reimbursement shall be a monthly fee established by OMRDD in conjunction with the New York State Department of Health and approved by the New York State Division of the Budget.

TN 00-07 Approval Date JAN 10 2000  
Supersedes TN 91-53 Effective Date MAR 01 2000

**TYPE OF SERVICE**

Case Management Services  
Target Group D:

Medicaid eligible individuals who are served by the New York State Office of Mental Health's Intensive Case Management Region and who

- (i) are seriously and persistently mentally ill and
- (ii) require intensive, personal and proactive intervention to help them obtain service, which will permit or enhance functioning in the community and
- (iii) either have symptomatology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

**METHOD OF REIMBURSEMENT**

For payment to Intensive Case Management providers in New York State a prospective cost based monthly rate shall be established for each provider. Providers may bill for the monthly rate only if the Medicaid eligible adult ICM client has been seen by the case manager a minimum of four times during the month. For Medicaid eligible seriously emotionally disturbed children in the ICM program, providers may bill for the monthly rate only if the case manager achieves a minimum of three face-to-face contacts with the client and the fourth face-to-face contact may be with either the client or a collateral, as defined in 14 NYCRR Part 587.4(a)(3).

Rates of payment shall be effective for the annual period ending June 30, for providers in New York City and for the annual period ending December 31, for the remainder of the State. Rates of payment for programs operated by state psychiatric centers shall be effective for the annual period ending March 31.

1. Monthly payments to individual ICM providers is at regional fees approved by the Department of Social Services.

2. The National Institute of Mental Health has approved a grant to the NYS Office of Mental Health to evaluate the effects, if any, of the method of reimbursement on the activities of case managers and the implications, if any, on client interactions and outcomes. The experimental reimbursement methodology provides fee-for-service reimbursement for individual and group face-to-face contacts between Intensive Case Manager and enrolled client as an alternative to the monthly payments paid to other ICM providers. This reimbursement methodology will be in place for the Visiting Nurse Service only for the period January 1, 1992 through December 31, 1992.

00-07  
Supersedes TN 95-48 Effective Date MAR 01 2000  
Approval Date JAN 10 2000

**TYPE OF SERVICE**

Case Management Services  
Target Group D1:

Medicaid eligible individuals who are served by the New York State Office of Mental Health's Intensive Case Management Program and who:

- (i) are seriously and persistently mentally ill and
- (ii) require intensive, personal and proactive intervention to help them obtain service, which will permit or enhance functioning in the community and
- (iii) either have symptomatology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

**METHOD OF REIMBURSEMENT**

For payments to Flexible Intensive Case Management providers in New York State a monthly fee shall be established for each provider and approved by the Division of the Budget. Providers may bill for the monthly rate only if the Medicaid eligible adult ICM client has been seen by the case manager a minimum of two times during the month. Clients who appear to be ready for disenrollment from the program can be deemed to be in transitional status, and the program can bill during that period if the client receives a minimum of one visit, but in no instance may a client remain in transitional status for more than two months.

The program as a whole must provide in the aggregate four visits times the number of Medicaid recipients per month per case manager. For seriously and emotionally disturbed children's programs/providers, up to 25% of the total required aggregate visits may be made to collaterals as defined in 14NYCRR Part 587.

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Supersedes TN [REDACTED] Effective Date DEC 01 2002

NEW (per cms 3/24/03)

**OFFICIAL**

**NEW YORK**

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**TYPE OF SERVICE**

Case Management Services  
Target Group D2:

Medicaid eligible individuals who:

- (i) are seriously and persistently mentally ill, and
- (ii) require intensive, personal and proactive intervention to help them obtain service, which will permit or enhance functioning in the community, and
- (iii) either have symptomatology which is difficult to treat in the existing mental health care system; or are unwilling or unable to adapt to the existing mental health care system; or need support to maintain their treatment connections and/or residential settings.

**METHOD OF REIMBURSEMENT**

Each Flexible and Blended Case Management program will receive a regional rate approved by the Division of the Budget determined by its staffing combination (i.e., the number of Intensive Case Managers and Supportive Case Managers on a particular team). No bill can be generated for a particular client unless that client has received at least two face-to-face contacts during the month. [However, in order to bill] The program as a whole is required to [must] provide in the aggregate four visits times the number of Medicaid recipients per month per Intensive Case Management staff and two times the number of Medicaid recipients per month per Supportive Case Manager. For seriously emotionally disturbed children's programs or providers, up to 25% of the total required aggregate Intensive Case Management visits may be made to collaterals as defined in 14 NYCRR Part 587. For those programs which do not achieve the required number of contacts, billings associated with the difference between the required number of contacts and achieved number of contacts shall be withheld pursuant to a schedule furnished to the provider by the Office of Mental Health. Clients who appear [to be] ready for disenrollment from the program can be placed into transitional status. The program can bill for the individual in transitional status during that [period] month if the client receives a minimum of one visit, but in no instance may a client remain in transitional status for more than two months.

TN 04-46 Approval Date MAR 17 2005

Supercedes TN 02-45 Effective Date OCT 01 2004  
01-02

**TYPE OF SERVICE**

Case Management Services  
Target Group: F

**METHOD OF REIMBURSEMENT**

The targeted group consists of the categorically needy or medically needy who meet one or more of the following criteria.

Provider-specific rates are replaced with a regional rate structure.

Certain individuals residing in areas of New York State designated as underserved and economically distressed through the State's Neighborhood Based Alliance (NBA) Initiative. Under Chapter 657 of the Laws of 1990, the NBA is targeting state money, resources and services to designated areas in order to alleviate the pervasive and detrimental effects of poverty, lack of access to services and lack of services.

The rate structure is based upon the identification of direct service components and incorporates a percentage allowance for indirect costs, based upon historical data.

Case management targeted individuals are those residents of the NBA areas who are experiencing chronic or significant individual or family dysfunction's which might be ameliorated through effective case management referral and monitoring of service provision. Such dysfunction's are assessed as chronic or significant by the case manager in accordance with an assessment tool approved by the Office of Children and Families. The assessment will determine chronic or significant dysfunction on the following categories or characteristics:

The following are the direct service components of the rate:

- (i) school dropout
- (ii) low academic achievement
- (iii) Poor school attendance
- (iv) Foster care placement
- (v) Physical and/or mental abuse or neglect
- (vi) Alcohol and/or substance abuse
- (vii) Unemployment/underemployment
- (viii) Inadequate housing or homelessness
- (ix) family court system involvement
- (x) criminal justice system involvement
- (xi) poor health care
- (xii) family violence or sexual abuse

Personal Services: Case Manager salary.

Fringe Benefit: Rates were established at the average fringe rate for New York City, Greater Metropolitan and Upstate New York.

Other cost percentage will constitute a percentage of allowable costs other than case manager salary and fringe benefits such as equipment, rentals, utilities, etc.

The Rate Calculation Formula:

Direct costs/% Direct cost (%)

Billable Hours/4=Quarter Hour Rate.

Billable hours are defined as the total of all case managers time attributable to direct client service in the various components of case management e.g.

N 00-07 Approval Date JAN 10 2001  
Supersedes TN 99-03 Effective Date MAR 01 2000

F

New York

Attachment 4.19-B  
Page 10-5

**METHOD OF REIMBURSEMENT**

Intake/screening, assessment, reassessment, monitoring, follow-up of crisis intervention.

Regionally calculated percentages have been determined for New York City, Greater Metropolitan New York and Upstate New York.

**Trend Factor:**

The rate will be adjusted by application of a trend factor approved by the Division of the Budget.

TN 00-07 Approval Date JAN 10 2001  
Supersedes TN 95-48 effective Date MAR 01 2000

**TYPE OF SERVICE:**

Case Management Services  
Target Group G:

Medicaid eligible clients who are served by the New York State Department of Health's Early Intervention Program and who:

1. are infants and toddlers from birth through two years who have a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay;
2. have been referred to the municipal early intervention agency; and
3. are in need of ongoing and comprehensive rather than incidental case management services.

**METHOD OF REIMBURSEMENT**

Reimbursement for necessary case management services provided to the client and to the family in support of the primary client under the New York State Early Intervention Program shall be at hourly rates established by the New York State Department of Health and approved by the Director of the Budget. Providers will be allowed to bill in quarter hour units.

Rates for case management will be set prospectively and will cover labor, administrative overhead, general operating and capital costs. The rates are also adjusted to reflect regional differences in costs. The regional classification system used to reflect differences in costs is described in 86-2.10(c)(5) of Attachment 4.19-A of the State Plan.

TN 00-07 Approval Date JAN 10 2001  
Supersedes TN 96-47 Effective Date MAR 01 2000

New York  
10-7

Attachment 4.19B  
(6/02)

**Target Group G - Early Intervention**

Existing rates of reimbursement, for approved early intervention services provided on and after December 1, 2002, shall be increased by three percent. The Commissioner of Health is authorized to require any early intervention provider, with the exception of self-employed early intervention providers, to submit a written certification attesting that such funds were or will be used solely for the purpose of recruitment and retention of early intervention service providers during the 2002-03 state fiscal year.

TN 02-45 Approval Date FEB 27 2003  
Supersedes TN New Effective Date DEC 01 2002

New York

Attachment 4.19-B

Page 11

TYPE OF SERVICE

Case Management Services

Target Groups: A & E

METHOD OF REIMBURSEMENT

- A. Categorically or medically needy  
Persons under age 21, pregnant  
Parenting or at risk of pregnancy

Provider-specific rates are replaced with a regional rate structure.

The rate structure is based upon the identification of direct service components and incorporates a percentage allowance for indirect costs, based upon historical data.

- E. Categorically or medically needy women of child-bearing age who are pregnant, and infants under one year of age.

The following are the direct service components of the rate:

Personal Services: Case manager salary.

Fringe Benefit: Rates were established at the average fringe rate for New York City, Greater Metropolitan and Upstate New York.

Other cost percentage will constitute a percentage of allowable costs other than case manager salary and fringe benefits such as equipment, rentals, utilities, etc.

The Rate Calculation Formula:

Direct costs / % Direct cost  
(%) / Billable hours / 4 = Quarter Hour Rate.

TN 99-03 Approval Date AUG 5 1998

Supersedes TN 97-10 Approval Date APR 1 1999

A+E

New York

Attachment 4.19-B

Page 11-1

METHOD OF REIMBURSEMENT

Billable hours are defined as the total of all case managers time attributable to direct client service in the various components of case management e.g. intake/screening, assessment, reassessment, monitoring, follow-up of crisis intervention.

Regionally calculated percentages have been determined for New York City, Greater Metropolitan New York and Upstate New York.

Trend Factor:

The rate will be adjusted by application of a trend factor approved by the Division of the Budget.

TN 99-03

Approval Date AUG 5 1999

Supersedes TN New

Effective Date APR 1 1999

Type of Service  
Case Management Services  
Target Group: C

Method of Reimbursement

C. Categorically or medically needy women of child-bearing age, clients of Community Services Programs or Community Based Programs, children and adolescents through 20 years of age who are HIV+ and categorically or medically needy women with children who are of negative or unknown serostatus, but who are at risk of HIV infection as a result of their personal activities or the activities of a sexual partner.

The proposed methodology includes the following characteristics:

- o Provider-specific rates are replaced with a regional rate structure;
- o Economics of scale associated with larger programs are accounted for;
- o Direct service components are established with a fixed percentage allowance for indirect costs.
- o An annual trend factor approved by the State Division of the Budget is applied in subsequent years;
- o Billable hours continues to be used as the basis for billing. The procedure used to calculate billable hours is modified to recognize non-billable responsibilities and to encourage improved service quality.

Regional Rate

Reimbursement amounts will be established for New York City Metropolitan area and for the rest of the state based on the expected costs in those areas of each direct services component. The New York City metropolitan region will consist of the following counties: Nassau, Suffolk, Rockland, Westchester and the five boroughs of New York City.

Program Size Differential

The rate structure will reflect the economy of scale produced by larger programs. Reimbursement for larger programs will decrease

TN 98-58

Supp. order TN 90-56

SEP 19 1994

JAN 1 - 1994

based upon the following criteria:

Rate A: For provider with 0 to 6 billable FTE staff.

Rate B: For providers with more than 6 to 12 billable staff.

Rate C: For providers with more than 12 FTE billable staff.

Direct Service Components

The rate structure is based upon the identification of direct services components and incorporates a percentage allowance for indirect costs.

The following are the direct service components of the rate.

Personal Services: Case manager salary, case management technician salary, community follow-up worker salary and the program director salary at 50% FTE.

Fringe Benefits: Rates were established at the average fringe rate for the metropolitan and rest of state regions.

Other Direct Costs: Quality Assurance Consultant Service, training cost for CM staff, travel cost for direct staff, conference registration costs for AIDS Institute conference, crisis intervention service costs, escort costs - security.

Indirect Cost Percentage

Direct service will constitute 72% of the total allowable costs with the remaining 28% available for Indirect costs such as equipment, rentals, utilities, etc.

TN 93-58

Supervisor 90-56 Date SEP 19 1994  
Date JAN 1 - 1994

The Rate Calculation Formula:

Direct costs/% Direct cost (72%) /  
Billable Hours/4 = Quarter Hour Rate

(Billable hours are defined as the total of all case managers time attributable to direct client service in the various components of case management e.g. intake/screening, assessment, reassessment, monitoring, follow-up of crisis intervention.)

Trend Factor:

The rate will be adjusted annually by application of a trend factor drawn from the U.S. Department of Labor Statistics Economic Cost Index for civilian workers by industry division, services line; 12 months ending June 1993, and that future year rates be based on this trend factor.

TN 93-58

Superseded by 90-56

SEP 19 1994

JAN 1 - 1994

TYPE OF SERVICE

Case Management Services  
Target Group H:

The target group consists of medical assistance eligibles who are served by the Office of Mental Health's Supportive Case Management Program and who:

- (i) are seriously mentally ill; and
- (ii) require personal and proactive intervention to help them obtain and maintain services, which will permit or enhance functioning in the community; and,
- (iii) either have symptomology which is difficult to treat in the existing mental health care system or need support to maintain their treatment connections and/or residential settings.

These individuals include:

- (1) heavy service users who are known to staff in emergency rooms, acute inpatient units, and psychiatric centers as well as to providers of other acute and crisis services, who may have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities; or
- (2) persons with recent hospitalizations in either state psychiatric centers or acute care general hospitals; or,

METHOD OF REIMBURSEMENT

Provider Reimbursement for Target Group H

For payment to Supportive Case Management providers in New York State, monthly fees shall be established for each region for SCM Medicaid programs which are not OMH operated and Statewide fees for SCM Medicaid programs operated by OMH. Providers may bill for the monthly fee only if the medicaid eligible recipient has been seen by the case manager a minimum of two times during the month. Clients ready for disenrollment may be placed into "transitional" status for a period not to exceed two months, and during that period the program/provider can bill for a maximum face to face contact of one visit per month. The minimum amount of time required for a client encounter to be credited for the purpose of Medicaid reimbursement is 15 minutes.

The fees for SCM providers will be recommended by OMH, and approved by the State Division of the Budget (DOB). OMH will consult with DOH and DOB regarding any changes to the regulations.

- 1. The regional fees for SCM Medicaid providers which are not OMH operated shall be based upon OMH approved expenditures per SCM in each OMH region and the maximum caseload per SCM approved by OMH for the individual provider. These regional fees shall be developed as follows:

TN 01-02 Approval Date JUN 19 2001  
 Supersedes TN 9440 Effective Date JAN 01 2001

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New York

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- (3) mentally ill who are homeless and live on the streets or in shelters; or,
- (4) seriously emotionally disturbed children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and who may, without intervention, be institutionalized, incarcerated or hospitalized; or,
- (5) people in need of ongoing mental health support in order to maintain or enhance community tenure.

The aim is to benefit these recipients by reducing hospitalization and reliance on emergency psychiatric services, as well as increasing employment, encouraging better medication management and generally improving the individual's quality of life within the community.

METHOD OF REIMBURSEMENT, con.

- a) Each SCM provider shall be approved for maximum monthly caseloads per SCM employed by the provider of either 20 or 30 enrolled clients.
  - b) The regional monthly fee for SCM providers approved for 20 clients shall be the OMH approved expected expenditures per SCM in the region divided by the product of 20 x 12 months x 90%.
  - c) The regional monthly fee for SCM providers approved for 30 clients shall be the OMH approved expected expenditures per SCM in the region divided by the product of 30 x 12 months x 90%.
2. The State monthly fees for SCMs employed directly by OMH in either free standing or shared staff arrangements with caseloads of 20 clients or 30 clients shall be the lesser of fees established using the methodology described in 1, above, or fees prescribed by DOB.

TN 01-02 Approval Date JUN 19 2001  
 Supersedes TN 94-40 Effective Date JAN 01 2001

New York

Attachment 4.19-B  
Page 11-F

**TYPE OF SERVICE:**

Case Management Services  
Target Group I:

Reimbursement for services provided to Target Group I, as described in Supplement 1 to Attachment 3.1A, pages I-1 thru I-18..

**METHOD OF REIMBURSEMENT**

Reimbursement for case management services provided to children under the New York SSHSP and PSHSP shall be at fees established by the Department of Health and approved by the Director of the Budget.

TN 96-41 Approval Date JAN 21 1998  
Superseded TN New Date 1997-9

**OFFICIAL**

New York  
11(f)(1)

Attachment 4.19-B  
(09/10)

The New York State (NYS) School Supportive Health Services Program (SSHSP)  
Targeted Case Management (TCM) for Target Group I, which became effective on  
October 3, 1996, is terminated on July 1, 2010.

TN#: 10-35

Approval Date: DEC 14 2010

Supersedes TN#: New

Effective Date: JUL 01 2010

**OFFICIAL**

11(g)

Attachment 4.19-B  
(10/09)

Case Management Target Group M Method of Reimbursement:

Rate Methodology for Targeted Case Management Services for First-time Mothers/Newborns

Visit-based rates have been calculated for Targeted Case Management services for the First-Time Mothers/Newborn Program. The rates will allow for costs of nurses, supervisors, fringe benefits and overhead related to providing targeted case management services only. Rates are based on a two and one-half year program cycle. The maximum length of a visit is sixty ~~30~~<sup>30</sup> minutes and is billed in fifteen-minute increments with a maximum of two-hundred and sixty increments.

Allowable nursing and nursing supervisor salaries are determined based on a time study and an analysis of registered nurses' salaries in the counties in the state that will be providing targeted case management services. The allowable number of supervisors for reimbursement purposes is based on a time study and is to not exceed one supervisor per seven nurses. The allowable number of nurses for reimbursement purposes is based on a time study and is to not exceed one nurse per 24 clients. Fringe benefits are capped at thirty percent (30%) of salaries of agency nurses and supervisors, and agency overhead is capped at twenty-five (25%) of agency nurse and supervisor salaries and fringe benefits.

The total percentage of fringe costs is calculated by dividing the fringe benefit amount by the total amount of agency nurse and supervisor salaries and is capped at 30% of the salaries of agency nurses and supervisors. The total percentage of agency overhead costs is calculated by adding the totals of all other agency administrative and overhead costs (agency costs exclusive of nurse salaries, supervisor salaries and fringe benefits), and then dividing this amount by the total of agency nurses and supervisors salaries and allowable fringe benefit expenditures and is capped at 25% of the allowable salaries and fringe benefits of agency nurses and supervisors.

Hourly rates are calculated by dividing total allowable agency expenditures by the total number of nurse-hours in one year. This amount is divided by four (4) to determine the 15-minute incremental unit-of-service in which the visit will be billed.

The agency's rates were set as of May 1, 2009 and are effective for services on or after that date. All rates are published in the various program manuals and are also available upon request from the State agencies involved. Except as otherwise noted in the plan, state developed fee schedules rates are the same for both governmental and private providers.

*\* The approved version contained a typographical error which has been corrected by pen and ink. Correct period of visit is 60 minutes. B.P. Wauson, Registrar III*

TN#:       #07-57      

Approval Date:       APR 06 2010      

Supersedes TN#:       New      

Effective Date:       APR 01 2009

FFY 1986 Medicaid Utilization Data  
for Selected Physician Procedure Codes

PROCEDURE	CLAIMS	AMOUNT PAID	RECIPS	AVG. \$/CLAIM
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MATERNITY CARE AND DELIVERY

VAGINAL DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

59400	14,548	\$12,857,012	11,448	\$883.96
59409	21,257	\$13,524,498	19,801	\$683.24
59410	32,471	\$21,048,830	30,088	\$698.23
59414	170	\$5,847	167	\$34.39
59430	2,616	\$108,433	2,318	\$41.83

CESAREAN DELIVERY

59510	7,392	\$3,835,548	5,705	\$491.82
59514	7,404	\$3,589,728	6,204	\$484.84
59515	13,812	\$5,803,088	10,818	\$420.15
59525	10	\$1,148	8	\$114.80

PEDIATRIC PRACTITIONER SERVICES

IMMUNIZATION INJECTIONS

90701	57,488	\$832,025	48,204	\$16.73
90712	124,499	\$2,088,330	97,100	\$16.77
90737	45,753	\$832,702	38,987	\$18.20

EVALUATION AND MANAGEMENT

99201	9,734	\$82,548	9,474	\$9.51
99202	72,211	\$836,025	68,971	\$11.56
99203	86,220	\$1,137,787	80,038	\$13.20
99204	116,758	\$2,401,228	108,837	\$20.57
99205	37,125	\$871,248	35,138	\$23.47
99211	123,478	\$883,475	71,894	\$7.98
99212	934,108	\$10,124,987	371,351	\$10.84
99213	978,713	\$11,458,482	373,798	\$11.68
99214	583,111	\$10,781,701	288,708	\$18.48
99215	83,582	\$1,852,885	53,278	\$22.17

PREVENTIVE MEDICINE SERVICES

99381	2,383	\$73,922	2,342	\$31.02
99382	1,983	\$62,536	1,874	\$31.54
99383	1,738	\$58,288	1,677	\$33.54
99384	1,014	\$32,917	987	\$32.48
99391	8,617	\$267,583	5,248	\$31.08
99382	12,738	\$419,084	10,208	\$32.91
99383	7,633	\$256,918	7,375	\$33.53
99384	3,412	\$108,288	3,333	\$31.14

RECEIVED

10/2/86  
DVA

TN 97-11 Approval Date APR 23 1987

Supersedes TN 97-11 Effective Date APR 01 1987

SOURCE: FFY 1986 PHYSICIAN AND CTHP 8079 REPORTS.  
QUESTIONS: NANCY HANSEN @ 518-473-8797.

New York State Department of Health  
Office of Medicaid Management  
February 28, 1997  
State Plan for April 1, 1997 - March 31, 1998

Region	OB/GYN		Family Practitioner		Pediatricians	
	Estimated Physicians	Participating Physicians	Estimated Physicians	Participating Physicians	Estimated Physicians	Participating Physicians
I	221	199	279	268	344	402
II	189	173	177	135	326	344
III	227	245	380	370	288	319
IV	188	185	324	321	266	290
V	967	775	602	508	1757	1620
VI (NYC)	1073	770	373	361	1901	1936
Rest of State	1792	1577	1762	1602	2981	2975
Statewide	2865	2347	2135	1963	4882	4911

Source: Participating Physicians: PVR 661 Report run date 12/10/96.

Approval Date

TN

February 1997-New York  
Preferred Physician & Childrens Program

<u>Upstate</u>		<u>Downstate</u>
W5000* \$36.00	Well Child - Healthy New Borns & Children Under 18 years	\$44.00
W5000* \$33.00	Class I Condition	\$39.00
W5000* \$31.00	Medication Administration	\$37.00
W5000* \$42.00	Generally Healthy Children 17-21	\$50.00
W5000* \$37.00	Class II Condition	\$44.00
W5000* \$38.00	Gynecological Exam Females under 21 years	\$45.00
W5000* \$37.00	Reproductive - all patients males or females under 21 w/reproductive	\$44.00
W5000* \$38.00	Class III Condition	\$45.00
W5000* \$69.00	Chemotherapy	\$83.00
W5000* \$44.00	Class IV Condition	\$53.00
W5000* \$36.00	Class V Condition	\$42.00
W5000* \$29.00	Ophthalmology	\$34.00

TN 97-11 Approval Date APR 23 1997  
Supersedes TN 96-11 Effective Date APR 01 1997

W5000*	Default - used when there is some minor information missing from a valid claim	\$29.00
\$34.00		
W5004*	Emergency Room Visit	\$36.00
\$30.00		
	(OB/GYN)	
W5000	1st Prenatal - females under 21 years with confirmed pregnancy	\$83.00
\$67.00		
W5000	Prenatal revisits - females under 21 years with confirmed pregnancy	\$48.00
\$40.00		
W5000	Postpartum pregnant females under 21 years (revised 1/94)	\$42.00
\$50.00		

TN 97-11 Approval Date APR 23 1997  
 Supersedes TN 96-11 Effective Date APR 01 1997

**MEDICAID OBSTETRICAL AND MATERNAL SERVICES (MOMS)  
PROCEDURE AND FEE SCHEDULE  
Current as of February 1997**

59400	Global Fee	\$1440.00
59410	Vaginal Delivery or Cesarean	\$ 960.00
59420	Antepartum care only initial visit	\$ 69.00
W0003	Antepartum care only subsequent visit	\$ 59.00
59430	Postpartum care only	\$ 59.00

TN 97-11 Approval Date APR 23 1997  
Supersedes TN 96-11 Effective Date APR 01 1997

**Child Teen Health Program  
As of February 1997**

**NEW PATIENT**

99384	Initial history and examination related to the healthy individual, including anticipatory guidance; adolescent (age 12 through 17 years)	\$29.00
99383	late childhood (age 5 through 11 years)	\$29.00
99382	early childhood (age 1 through 4 years)	\$29.00
99381	infant (age under 1 year)	\$29.00
99381	not listed separately procedure code 99831 should be used.	

**ESTABLISHED PATIENT**

99394	Interval history and examination related to the healthy individual, including anticipatory guidance; periodic type of examination; adolescent (age 12 through 17 years)	\$29.00
99393	late childhood (age 5 through 11 years)	\$29.00
99392	early childhood (age 1 through 4 years)	\$29.00
99391	infant (age under 1 year)	\$29.00

TN 97-11 Approval Date APR 01 1987  
 Supersedes TN 96-11 Effective Date APR 01 1987

APR 23 1987

APR 01 1987

Health Maintenance Organization (HMO) Obstetrical and Pediatric Services:

Section 6306.3 requires that data on HMO obstetrical and pediatric services be given.

Health Maintenance Organizations with Section 1903 (m) Medicaid contracts must offer medical benefit packages that include pediatric and obstetrical services which, at a minimum, must be equal in scope and accessibility as that available to the HMO's are prospectively negotiated, monthly capitation rates which represent payment in full for all the services provided by the HMO's to their Medicaid membership.

The capitation rates are developed by a nationally known expert actuarial firm, and are capped at a percentage of historical Medicaid fee for service costs, which are trended and adjusted to reflect current Medicaid cost experience, including the costs of obstetrical and pediatric services. In many cases the HMO'S themselves have chosen to pay their health care practitioners the same rates of payment or use the same payment methodology for service members. Thus the availability of pediatric and obstetrical services to Medicaid recipients enrolled in HMO's is equal to that available to the HMO's general membership.

TN 97-11 Approval Date APR 23 1997  
Supersedes TN 96-11 Effective Date APR 01 1997

## New York State Department of Social Services Regions

REGION	DISTRICTS	
I	Allegany Cattaraugus Chautauqua Erie	Genesee Niagara Orleans Wyoming
II	Chemung Livingston Monroe Ontario Schuyler	Seneca Steuben Wayne Yates
III	Broome Cayuga Chenango Cortland Herkimer Jefferson Lewis	Madison Oneida Onondaga Oswego St. Lawrence Tioga Tompkins
IV	Albany Clinton Columbia Delaware Essex Franklin Fulton Greene Hamilton	Montgomery Otsego Rensselaer Saratoga Schenectady Scholarie Warren Washington
V	Dutchess Nassau Orange Putnam Rockland	Suffolk Sullivan Ulster Westchester
VI	New York City	

TN 97-11 Approval Date APR 23 1987  
Supersedes TN 96-11 Effective Date APR 01 1987

TYPE OF SERVICE

Emergency Services for Illegal  
Aliens

METHOD OF REIMBURSEMENT

Reimbursement for treatment of  
emergency medical conditions for  
aliens not lawfully admitted for  
permanent residency or otherwise  
permanently residing in the United  
States under color of law shall be  
in the same amount (fee or rate  
dependent on provider type) as for  
all other Medicaid eligibles.

TN 87-47 Approval Date NOV 21 1991  
Supersedes TN NEW Effective Date

**Clinic Services for Federally Qualified Native American Health Centers not subject to licensure under Article 28 of the State Public Health Law**

Reimbursement for federally qualified health centers located on Native American reservations and operated by Native American tribes or tribal organizations pursuant to applicable Federal Law and for which State licensure is not required will be established consistent with the methodology applicable to freestanding diagnostic and treatment centers, including federally qualified health centers which are licensed under Article 28 of the State Public Health Law. The reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Prospective all inclusive rates of payment will be calculated by the Department of Health, based on the lower of allowable average operating costs per visit or the group ceiling trended to the current year as permitted by law, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, [2000] 2003. The facilities will be compared with other facilities offering similar types of services. The rates will include a capital component which is not subject to ceiling limitations. Rates are subject to approval of the Division of the Budget. The facilities will be required to forward to the Department of Health on an annual basis any necessary financial and statistical information.

The provisions of this section pertaining to reimbursable base year administrative and general costs of a provider of services shall be deemed to be in full force and effect through March 31, 1999, and from July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003.

The facility specific impact of eliminating the statewide cap on administrative and general costs, for the period April 1, 1999 through June 30, 1999 shall be included in rates of payment for facilities affected by such elimination for the period October 1, 1999 through December 31, 1999.

TN 00-01 Approval Date JUN 06 2001  
Supersedes TN 99-43 Effective Date JAN 01 2000  
99-37  
99-27

New York  
14(a)

Attachment 4.19B  
9/99

**Methods and Standards for Establishing Payment Rates for Indian Health Service and Tribal 638 Outpatient Facilities**

- Indian Health Service outpatient facilities are paid the outpatient per visit rate published in the Federal Register.
- Tribal 638 outpatient facilities are paid using the outpatient per visit rate published in the Federal Register.
- Indian Health Service outpatient facilities are paid using the same methodologies and standards as non-IHS facilities of the same type.
- Tribal 638 outpatient facilities are paid using the same methodologies and standards as non-Tribal facilities of the same type.
- Indian Health Service outpatient facilities are paid using the methodology described below:
- Tribal 638 outpatient facilities are paid using the methodology described below:

Tribal 638 outpatient facilities, operating as diagnostic and treatment centers and designated by the Department as eligible facilities, are paid using the outpatient per visit rate published in the Federal Register, as an all inclusive rate for medical services as otherwise provided by diagnostic and treatment centers licensed under Article 28 of the Public Health Law.

DEC 6 1999  
TN 99-39 Approval Date DEC 6 1999  
Supersedes TN New Effective Date JUL 1 1999

**OFFICIAL**

Reimbursable Assessment on Ambulatory Care Services

[Assessments]

Effective January 1, 1997, rates of payment for outpatient services provided by general hospitals including referred ambulatory services and emergency services, and diagnostic and treatment centers providing a comprehensive range of primary health care services or ambulatory surgical services shall be increased by 5.98 percent to reimburse an assessment on net Medicaid patient service revenues. For services provided on and after July 1, 2003, the percentage shall be increased from 5.98% to 6.47%.

Effective October 1, 2000, reimbursement of the [5.98%] assessment on Medicaid net patient service revenue received for referred ambulatory clinical laboratory services of hospitals and diagnostic and treatment centers will be discontinued.

Effective January 1, 2006, an assessment on net patient services revenue for the ambulatory care services identified above that are rendered to Medicaid beneficiaries shall be considered an allowable cost and reimbursed through an adjustment to Medicaid services rates of payment.

TN #06-08

Approval Date

JUN 20 2006

Supersedes TN #03-31

Effective Date

JAN 01 2006

TYPE OF SERVICE

Primary Care Case Management

METHOD OF REIMBURSEMENT

PCCMs may be reimbursed on a capitated or fee-for-service basis and may be paid case management fees. If capitated, the capitation will cover primary care services routinely provided in a primary care practitioner's office.

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TN NO. 00-43  
Supercedes  
TN

Approval Date

Effective Date **OCT 01 2000**

TN 00-43 Approval Date **MAR 28 2000**

**OCT 01 2000**

**OFFICIAL**

New York  
16(a)

Attachment 4.19-B  
(01/04)

**Hyperbaric Oxygen Therapy (HBOT)**

The Department of Health will continue to conduct a pilot reimbursement program for a period of three additional years to study and determine the efficacy of funding certain outpatient HBOT services provided by select hospitals in New York State.

- (a) Hospitals will be selected based upon their experience in providing outpatient HBOT services and pending appeals to establish specialty outpatient HBOT rates of reimbursement, which were submitted to the Department no later than January 25, 2000. In order to participate in the program, such hospitals will be required to submit quarterly reports to the Department that include specific measurable outcomes in order to determine the effectiveness of the program.
- (b) Outpatient HBOT services covered by Medicaid in this pilot program include only those listed in Section 35-10A of the Medicare Coverage Issues Manual published by the [Health Care Financing Administration] Centers for Medicare And Medicaid Services.
- (c) The payment rate for outpatient HBOT services provided in accordance with Section 35-10A of the Medicare Coverage Issues Manual shall be the current Medicare APC rate paid through the hospital outpatient prospective payment system.

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Type of Service

Program of All-Inclusive Care  
for the Elderly (PACE)

Method of Reimbursement

The Department uses the following process in establishing rates: The Department will determine a fee-for-service equivalent per member per month cost for State Plan approved services provided to an equivalent non-enrolled population group. This information; and/or any information received from the PACE provider, such as the provider's anticipated enrollment, projected utilization of services and costs, cost experience, and indirect/overhead costs; and/or any other relevant information, will be used by the Department to determine a per member per month capitation rate for the provider that is less than the fee-for-service equivalent per member per month cost determined by the Department.

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TN No.: **02-01** | SEP 03 2002  
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Upper Payment Limit and Rate Methodology

The methodology used by New York State to determine a Medicaid capitation PMPM rate for a PACE provider follows a two-step process. First, the Department determines a fee-for-service equivalent per member per month cost for State Plan approved services provided to an equivalent non-enrolled population group. This is called the Upper Payment Limit (UPL). Then, this cost level, and/or any information received from the PACE provider, such as the provider's anticipated enrollment, projected utilization of services and costs, and/or any other relevant information, are used by the Department of Health to determine a per member per month capitation rate. This rate does not exceed the fee-for-service equivalent per member per month cost (i.e., the UPL in step one) developed by the Department.

In the following two sections, these two steps in the rate determination process are described in more detail.

Step 1: Development of the Upper Payment Limit (UPL)

The purpose of the Upper Payment Limit is for the State to ensure that the Medicaid monthly capitation payment amount for a PACE provider is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program.

The base period data file used by the Department for the purpose of developing the UPL's was an individual specific file on recipients, 55 years of age or older, of long term care services in New York State's fee-for-service program. These long term care services included community-based services as well as nursing home care. Only the costs of State Plan approved services from this data file were used for the development of the UPL's. The data file contained expenditures by category of service and eligibility category. Since the file was of recipients of long term care services under the State's Medicaid program, individuals qualifying under the QMB Only, QDWI, SLMB, Q11, and Q12 programs were by definition excluded from this data base. Furthermore, recipients enrolled in capitated Medicaid managed care programs, including PACE participants, and their services were excluded.

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In order to prepare the base period fee for service data file for further analysis, a number of adjustments were made. Claims completion factors were developed based on an examination of the data to determine the claims payment lag by service category. These completion factors were then applied to adjust the base period file expenditures. The pharmacy expenditures in the file were adjusted to net out the impact of rebates for pharmaceutical drugs. For transportation expenditures, an adjustment was made for payments not processed through the MMIS. In order to develop the UPL's for premium groups pertaining to Medicaid Only Eligible individuals, adjustments were also made to the hospital inpatient expenditures in the base period file to exclude graduate medical education (GME) payments, since PACE providers do not make a GME payment to their contracted hospitals.

Once the base period expenditure data were assembled and adjusted as described above, the data base was separated into the Medicare Medicaid Dual Eligible individuals and Medicaid Only Eligible individuals to proceed with UPL development. As a first step, analyses were undertaken to assess the need to smooth the data to improve the variability of rates and improve average predictability. For example, since it was intended that provider capitation rates and hence the UPL's were to be on a county specific level, an analysis was performed to determine whether significant cost variations existed across counties within a given region. A finding of such variation would suggest a smoothing adjustment. However, the analysis of the dual eligible population did not find that variations in costs within regions were significant and hence no smoothing adjustment was applied to the expenditure data for this purpose. No stop loss provisions are included in the PACE capitation rates and hence no such feature was reflected in the UPL development.

The analyses of the data base on the fee for service expenditures of individuals eligible for Medicaid Only found that the numbers of long term care recipients by county were extremely small for several counties. Hence, in lieu of UPL's developed on a county specific basis for the Medicaid Only Eligible population, region specific UPL's were developed. The regions used were New York City, Downstate Suburban, Upstate Urban, and Upstate non-Urban counties.

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The data were also examined to determine the appropriate rate category groupings. In lieu of age-based or gender-based rate groupings, the State chose to differentiate Upper Payment Limits by a "High" and a "Low" risk group based on an analysis of cost variation among fee-for-service enrollees. The "High" group was defined as representing individuals with a DMS-1 score of 180; the "Low" group represented individuals with a score of 60 to 179. The DMS-1 is the state-designated tool for determining nursing facility level of care. The UPL for each county, and the UPL for each region for the Medicaid-Only Eligible population, were separated into a "High" and "Low" category using these thresholds.

Using the base year fee-for-service expenditures as described above, updates of the UPL's for a given rate year were achieved through inflation factors based on State fee-for-service increases in rates for various categories of expenditures pertaining to the long-term care population. This update also included a review for program changes in fee-for-service long-term care for inclusion into the UPL's.

The methodology, as described above, produced Upper Payment Limits for the PACE eligible population, i.e., individuals who are Medicare-Medicaid dual eligible and are 55 years of age or older and certified for nursing home care, on a county-specific basis in rate period dollars. Separate UPL's were determined for the "High" and "Low" groups. Regional UPL's, separated into the "High" and "Low" categories were also produced for the PACE eligible population who have only Medicaid coverage and are 55 years of age or older.

Step 2: Provider Rate Proposal Submission and Rate Determination

This step constitutes the second step in the process of rate determination, with the UPL development (as described above) being the first. Each PACE provider submits a rate proposal to the State. The State provides the format, guidelines, and instructions for the rate proposal document. In the rate proposal, the provider is instructed to indicate anticipated enrollment, identify the types of services that will be provided to its enrollees, projected levels of utilization of services and the assumptions underlying these projections, and projected prices the provider will have to pay for these services. The rate proposal by a provider shows the monthly capitation rate being requested separately for the "High" and "Low" groups.

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~~The rate proposal submitted by the provider is reviewed by the State. This review evaluates the reasonableness of utilization projections, appropriateness of unit prices of services, provider arrangements, expected administrative expenditures, historical cost experience and other factors. The result of this review is a capitation rate, separately for the "High" and "Low" groups, determined by the State, after discussions with the plan. This capitation rate excludes the enrollee share amount based on the enrollee's applicable spenddown liability and Net Available Monthly Income (NAMI). The State ensures that the capitation rate approved for the provider does not exceed the appropriate upper payment limit (UPL) as developed in step one described above. The rate determined by the Department is subject to the approval of the State Division of the Budget.~~

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**Type of Service**

**Early and Periodic Screening, Diagnostic and Treatment services**

Early and Periodic Screening, Diagnostic and Treatment services for individuals under 21 years of age, and treatment of conditions found.

Reimbursement Methodologies for Early and Periodic Screening, Diagnostic and Treatment Services provided as the School Supportive Health Services (SSHS) and Pre-School Supportive Health Services (PSSHS) Programs

School Supportive Health Services (SSHS) and Pre-School Supportive Health Services (PSSHS) are delivered by or through a school district, a Section 4201 school, a county in the State or the City of New York and include the following Medicaid services as described in Appendix 1 to Attachment 3.1-A and B of the Medicaid State Plan under item 4.b, EPSDT.

1. Physical Therapy Services
2. Occupational Therapy Services
3. Speech Therapy Services
4. Psychological Counseling
5. Skilled Nursing Services
6. Psychological Evaluations
7. Medical Evaluations
8. Medical Specialist Evaluations
9. Audiological Evaluations
10. Special Transportation

Effective for dates of service on or after September 1, 2009, payments to a school district, a Section 4201 school, a county in the State or the City of New York for School Supportive Health Services and Pre-School Supportive Health Services shall be based on fees established by the Department of Health.

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Fees will be established for each service or procedure and, except for Special Transportation, such fees shall be set at 75% of the 2010 Medicare fee schedule for the Mid Hudson Region.

Fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts, Section 4201 schools, and counties in the state and the City of New York.

**1. Physical Therapy Services**

Fees for physical therapy services and procedures shall be set at 75% percent of the 2010 Medicare fee schedule for the Mid Hudson Region.

Fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance for school districts, Section 4201 schools, counties in the State and the City of New York.

**2. Occupational Therapy**

Fees for occupational therapy services and procedures shall be set at 75% of the 2010 Medicare fee schedule for the Mid Hudson Region.

Fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts, Section 4201 schools, counties in the State and the City of New York.

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**3. Speech Therapy Services**

Fees for speech therapy services and procedures shall be set at 75% of the 2010 Medicare fee schedule for the Mid Hudson region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts, Section 4201 schools, counties in the State and the City of New York.

**4. Psychological Counseling**

Fees for psychological counseling services shall be set at 75% of the 2010 Medicare fee schedule for the Mid Hudson Region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts, Section 4201 schools, counties in the State and the City of New York.

**5. Skilled Nursing Services**

Fees for skilled nursing services shall be set at 75% of the 2010 Medicare fee schedule for the Mid Hudson Region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts, Section 4201 schools, counties in the State and the City of New York.

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**6. Psychological Evaluations**

Fees for psychological evaluations shall be set at 75% of the 2010 Medicare fee schedule for the Mid Hudson Region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts, Section 4201 schools, counties in the State and the City of New York.

**7. Medical Evaluations**

Fees for medical evaluations shall be set at 75% of the 2010 Medicare fee schedule for the Mid Hudson Region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts, Section 4201 schools, counties in the State and the City of New York.

**8. Medical Specialist Evaluations**

Fees for medical specialist evaluations shall be set at 75% of the 2010 Medicare fee schedule for the Mid Hudson Region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts, Section 4201 schools, counties in the State and the City of New York.

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**9. Audiological Evaluations**

Fees for audiological evaluations shall be set at 75% of the 2010 Medicare fee schedule for the Mid Hudson Region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts, Section 4201 schools, counties in the State and the City of New York.

**10. Special Transportation**

One way rates of payment for special transportation services have been set based on a statistically valid cost study that was conducted in 1999 to establish round trip transportation rates. Such rates have been trended forward based on changes in the Consumer Price Index from 7/99 through 8/09 and converted to one way rates.

Such rates shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts, Section 4201 schools, counties in the State and the City of New York.

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State NEW YORK

Description of the Policy and the Methods  
to be Used in Establishing Payment Rates

CONFIDENTIAL

The Division of Health Economics of the New York State Department of Health has been charged with the responsibility of studying and determining fees for providers of medical and paramedical care.

In pursuit of these fee studies, the Division of Health Economics meets with the representative professional groups, studies published and unpublished fee surveys, makes comparisons with schedules of insurance carriers and Workmen's Compensation, and conducts informal surveys as the occasion demands.

When the Division of Health Economics develops a fee schedule which approximates average prevailing fees in the State, a fee schedule and supporting position paper are sent to all members of the Interdepartmental Committee on Health Economics. This Committee is composed of representatives from the Departments of Education (Division of Vocational Rehabilitation, Social Services, Health, Mental Hygiene, Correction, Civil Service, Insurance, Workmen's Compensation and the Division of the Budget. The Committee may approve the schedule as presented or make modifications. The schedule is then recommended to the Commissioner of Health who, if in agreement, recommends approval to the Director of the Division of the Budget. The Budget Director may then approve and promulgate the schedule.

Promulgated schedules apply to all State programs except Workmen's Compensation, and supersede all existing schedules including those previously promulgated by the Department of Education, Health and Social Welfare.

Fees contained in the schedules are to be considered full payment of the services rendered. Under the Medical Assistance Program, which is administered by local welfare districts, these fees represent maximum allowances for purposes of State reimbursement. Each local welfare district may determine the fees paid to practitioners for services to eligible recipients.

Fees for services or procedures which are not included in the fee schedule may be determined on an individual basis by the appropriate public agency. However, such determinations must be reported promptly to the Division of Health Economics which reviews the fee for the given procedure and subsequently recommends a fee for approval by the Interdepartmental Committee on Health Economics and for possible incorporation in the fee schedule.

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(04/03)

**Physician Services**

Fee Schedules are developed by the Department of Health and approved by the Division of the Budget.

For primary care and specialty physicians meeting the eligibility and practice criteria of and enrolled in the HIV Enhanced Fees for Physicians (HIV-EFP) program, and the Preferred Physicians and Children's program (PPAC), fees for visits are based on the Products of Ambulatory Care (PAC) structure: fees are based on recipient diagnosis, service location and visit categories which reflect the average amount of physician time and resources for that level of visit. The PAC fee structure incorporates a regional adjustment for upstate and downstate physicians. Reimbursement for the initial and subsequent prenatal care and postpartum visit for MOMS is [the same as PPAC] based on the Products of Ambulatory Care (PAC) rate structure. Reimbursement for delivery only services and total obstetrical services for physicians enrolled in MOMS is fixed at 90% of the fees paid by private insurers. Ancillary services and procedures performed during a visit must be claimed in accordance with the regular Medicaid fee schedule described in the first paragraph above. HIV-EFP, PPAC and MOMS fees were developed by the Department of Health and approved by the Division of the Budget. For services provided on and after June 1, 2003, a single fee, regionally adjusted (upstate and downstate) and based on program specific average cost per visit shall be established for the HIV-EFP and PPAC programs, respectively, and shall be paid for each visit. Visits for these programs shall be categorized according to the evaluation and management codes within the CPT-4 coding structure.

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93-30

**OFFICIAL**

**Statewide Patient Centered Medical Home - Physicians and/or Nurse Practitioners:**

Fee schedules developed by the Department of Health and approved by the Division of Budget will be augmented by incentive payments to physicians and/or nurse practitioners certified by the Department as patient centered medical homes.

Effective for periods on and after December 1, 2009, the Commissioner of Health is authorized to certify certain physicians' and nurse practitioners' practices as patient centered medical homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for primary care services provided to recipients eligible for Medicaid Fee-For-Service (FFS).

To improve access to high quality primary care services, the statewide Medicaid Patient Centered Medical Home initiative will provide incentive payments to providers who meet "medical home" standards established by the Department. Those standards will be consistent with the National Committee for Quality Assurance's Physician Practice Connections® -- Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program. Physicians and/or nurse practitioners achieving NCOA PPC®-PCMH™ recognition will be eligible for incentive payments for providing services to Medicaid FFS patients.

Per visit incentive payments will be made to physicians' and/or nurse practitioners' practices that meet the Department standards for certification as a patient centered medical homes, consistent with the NCOA PPC®-PCMH™ Program. There are three levels of "medical home" recognition: Levels 1, 2 and 3. Eligible providers will receive a per visit incentive payment commensurate with their level of "medical home" recognition. Incentive payments will be added to claims from NCOA recognized providers for visits with evaluation and management codes identified by the Department as "primary care."

To determine appropriate incentive payment amounts, the NY Medicaid Program conducted a review of "medical home" incentive payments nationally. Most programs paid medical home incentive payments on a per member per month (PMPM) basis. To work in the fee-for-service payment context, PMPM benchmark amounts used by programs in several other states (\$2, \$4, and \$6) were converted to per-visit payment amounts by first multiplying the PMPM payment by twelve (12) to calculate an annual per member payment, and then dividing the annual amount by the average number of annual primary care visits to practitioners' offices to arrive at a per-visit incentive payment amount for each level of medical home recognition.

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(10/09)

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as patient centered medical homes. The agency's fee schedule rates were set as of December 1, 2009 and are effective for services provided on or after that date. All rates are published on the State Department of Health's website.

Once a physician and/or nurse practitioner practice advances to a higher level of "medical home" recognition he/she will no longer be eligible for the lower level incentive payment per Evaluation and Management visit. A physician and/or nurse practitioner practice may only receive one level of incentive payment at a time for each eligible visit. Medical home incentive payments are only applicable to claims when Medicaid is the primary payer.

To maintain eligibility for incentive payments physicians' and/or nurse practitioners' practices must: a) renew their "patient centered medical home" certification at a frequency determined by the Commissioner; and b) provide data to the Department of Health to permit the Commissioner to evaluate the impact of patient centered medical homes on quality, outcomes and cost.

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**OFFICIAL**

**Adirondack Medical Home Multipayor Program – Physicians and/or Nurse Practitioners**

Fee schedules developed by the Department of Health and approved by the Division of the Budget will be augmented by incentive payments to physicians and/or nurse practitioner practices certified by the Department as participants in the Adirondack Medical Home Multipayor Program.

Effective for periods on and after December 1, 2009, certain clinicians and clinics in the upper northeastern region of New York State will be certified as health care homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for services provided to recipients eligible for Medicaid fee-for-service; enrollees eligible for Medicaid managed care; and enrollees eligible for and enrolled in Family Health Plus organizations pursuant to Title 11-D of Article 28 of the Public Health Law (PHL).

The Adirondack Medical Home Multipayor Program is a primary care medical home collaborative of health care service providers including hospitals, diagnostic and treatment centers and private practices serving residents and eligible recipients in the counties of Clinton, Essex, Franklin, Hamilton, Saratoga and Warren. Incentive payments to physicians and/or nurse practitioner practices that meet "medical home" standards will be established jointly by the State Department of Health, participating health care service providers and payors. Medical home certification includes, but is not limited to, existing standards developed by national accrediting and professional organizations, including the National Committee for Quality Assurance (NCOA) Physician Practice Connections® - Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program.

Under this program, incentive payments will be made for one year to participating providers to support conversion of physicians and/or nurse practitioner practices to certified medical homes. Within one year, providers in the Multipayor Program must achieve either Level 2 or Level 3 including additional criteria (referred to as Level 2 Plus and Level 3 Plus) as determined by the program participants in order to continue to receive the incentive payment. Eligible providers will receive the same incentive payment commensurate with the following levels of "medical home" designation: conversion support; Level 2 Plus; or Level 3 Plus. There will be no incentive payment for Level 1 designation. Incentive payments will be added to claims from program physicians and/or nurse practitioner practices for visits with Evaluation and Management codes identified by the Department of Health as "primary care."

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The incentive amount was determined by the Department of Health and participating payors based on a market analysis of the cost to support the conversion of a practice to provide "medical home" patient care and management information systems related to meeting the objectives of this initiative. The participating payors agreed to a per member per month (PMPM) incentive payment of \$7. To calculate the per-visit incentive payment amount the PMPM was multiplied by twelve (12) to calculate an annual per member payment (\$84) and then this annual amount was divided by the average number of annual primary care visits to clinics and practitioners' offices to arrive at a per visit incentive payment. The average annual visit rate, based on two years of claims data (January 1, 2007 – December 31, 2008) for a specific list of providers who agreed to participate in the Multipayor Program, was 3 visits per year. Therefore, the per visit incentive payment is \$28. The incentive amount will be approved by the Division of the Budget.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of primary care "medical home" services in the Multipayor Program. The agency's fee schedule rate was set as of December 1, 2009 and is effective for services provided on or after that date. All rates are published on the Department of Health public website.

Patient and health care services participation in the Adirondack Medical Home Multipayor Program is on a voluntary basis. While physician and/or nurse practitioner practices are participating in the Multipayor Program they are precluded from receiving incentive payments from the statewide patient centered medical home program established pursuant to section 364-m of the Social Services Law.

**E-prescription**

An e-prescription financial incentive will be paid to physicians for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the-counter medications prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

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1(A)(iii)

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An e-prescription financial incentive will be paid to physicians for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the counter medications prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

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New York

1(A)(iv)

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An e-prescription financial incentive will be paid to dentists for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the counter medications prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

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1(A)(v)

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**OFFICIAL**

An e-prescription financial incentive will be paid to podiatrists for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the counter medications prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

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1(A)(vi)

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An e-prescription financial incentive will be paid to optometrists for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the counter medications prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

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1(A)(vii)

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An e-prescription financial incentive will be paid to nurse midwives for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the counter medications prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

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New York

1(A)(viii)

**OFFICIAL**

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An e-prescription financial incentive will be paid to nurse practitioners for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the counter medications and supplies prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

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Type of Service

Method of Reimbursement

Dental Services  
(including dentures)

Payments are limited to the lower of the usual and customary charge to the public or the fee schedule developed by the Department of Health and approved by the Division of the Budget.

Podiatrists

Fee schedule developed by the Department of Health and approved by the Division of the Budget.

Optometrists

Fee schedule developed by the Department of Health and approved by the Division of the Budget.

Chiropractor's Services

Fee schedule developed by the Department of Health and approved by the Division of the Budget.

Nurse Midwives

Fee schedule developed by the Department of Health and approved by the Division of the Budget.

Nurse Practitioners

Fee schedule developed by the Department of Health and approved by the Division of the Budget.

Other Practitioner Services

Clinical Psychologists

Fee schedule developed by the Department of Health and approved by the Division of the Budget.

Outpatient Hospital Services/Emergency Room Services

For those facilities certified under Article 28 of the State Public Health Law: The Department of Health promulgates prospective, all inclusive rates based upon reported historical costs. Allowable operating costs per visit are held to legislatively established ceiling limitations. Reported historical operating costs on a per visit basis, which are below or limited by ceilings, are deemed reimbursable and trended forward to the current rate period to adjust for inflation. Non-operating costs (such as capital costs) are not subject to the legislatively established ceiling and are added to the product of reimbursable operating costs times the roll factor

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(two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, [2007] 2009, for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Renal dialysis services are reimbursed on the lower of a facility's actual cost or statewide ceiling of \$150.00 per procedure. Payment rates for renal dialysis services are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, shall be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of \$67.50 per visit. For dates of service beginning on December 1, 2008 through March 31, 2010, primary care clinic and renal dialysis services shall be reimbursed using the Ambulatory Patient Group classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however that for the period October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, [2007] 2009, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

Effective October 1, 1995, the rate for emergency services provided in primary care hospitals, shall be a per visit rate based upon allowable reportable operating costs and limited to a cap on operating costs of \$95 per visit provided however, that for the period January 1, 2007 through December 31, 2007 the maximum payment for the operating component shall be \$125 per visit; and during the period January 1, 2008 through December 31, 2008, the maximum payment for the operating cost component shall be \$140 per visit; and during the period January 1, 2009 through [December] March 31, [2009] 2010 [and for each calendar year thereafter, the maximum payment for the operating cost component shall be \$150 per visit] emergency department services shall be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however, that for the period of October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, [2007] 2009, the capital costs per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

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For outpatient services provided by general hospitals as noted in the proceeding paragraphs of this Section, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

All rates are subject to approval by the Division of the Budget. For emergency room services only, a retrospective adjustment may be made if it is determined that patients requiring general clinical services are provided such services in the emergency room for the sole purpose of maximizing reimbursement.

**Designated Preferred Primary Care Provider for Hospital-Based Outpatient Clinics and Hospital-Based Specialty Clinic Services**

Hospital-Based clinics seeking reimbursement as designated preferred primary care providers are required to enter into a provider agreement with the New York State Department of Health. Providers seeking reimbursement for certain outpatient specialty clinic services are required to document in writing and through site inspection or records review that they are in fact organized as and providing specialty services.

Reimbursement for providers designated as preferred primary care providers or for hospital based programs providing specialty clinic services is prospective and associated with resource use patterns to insure that ambulatory services are economically and efficiently provided. The methodology is based upon the Products of Ambulatory Care (PAC) classification system.

Under the reimbursement method, facility specific payment rates are established for each of the PAC groups. For each service, a rate is established to cover all labor, ancillary services,

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medical supplies, administrative overhead, general and capital costs. The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

For services provided on or after April 1, 1995 by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994 based on the reimbursement payment methodology described in this section, or by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995 for designation as a preferred primary care provider. The reimbursement methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating hospitals. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.

**Ordered Ambulatory Services (specific services performed by a hospital on an ambulatory basis upon the order of a qualified physician, physician's assistant, dentist or podiatrist to test, diagnose or treat a recipient or specimen taken from a recipient)**

Fee schedule developed by the Department of Health and approved by the Division of the Budget for each type of service, as appropriate.

Payment for these services will not exceed the combined

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payments received by a provider from beneficiaries and carriers or intermediaries for providing comparable services under Medicare.

### Trend Factors

Notwithstanding any inconsistent provision of this state plan, effective April 1, 2000, in those instances when trend factors are used in determining rates of payment for hospital outpatient services, diagnostic and treatment centers unless otherwise subject to the rate freeze set forth herein, certified home health agencies, and personal care services, the Commissioner of Health shall apply trend factors in accordance with the following:

- (1) For rate periods on and after April first, two thousand, the Commissioner shall establish trend factors for rates of payment for state governmental agencies to project for the effects of inflation except that such trend factors shall not be applied to services whose rate of payment are established by the commissioners of the department of mental hygiene. The factors shall be applied to the appropriate portion of reimbursable costs.
- (2) In developing trend factors for such rates of payment, the Commissioner shall use the most recent Congressional Budget Office estimate of the rate year's U.S. Consumer Price Index for all urban consumers published in the Congressional Budget Office Economic and Budget outlook after June first of the rate year prior to the year for which rates are being developed.
- (3) After the final U.S. Consumer Price Index (CPI) for all urban consumers is published by the United States Department of Labor, Bureau of Labor Statistics, for a particular rate year, the Commissioner shall reconcile such final CPI to the projection used in number two of this section and any difference will be included in the prospective trend factor for the current year.

Nothing in this section is intended to produce a change in any existing provision of law establishing maximum reimbursement rates.

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**Statewide Patient Centered Medical Home - Freestanding Clinics**

Effective for periods on and after December 1, 2009, the Commissioner of Health is authorized to certify certain clinics as patient centered medical homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for services provided to recipients eligible for Medicaid fee-for-service (FFS).

Clinic shall mean a general hospital providing outpatient care or a freestanding diagnostic and treatment center, licensed under Article 28 of the Public Health Law.

To improve access to high quality primary care services, the statewide Patient Centered Medicaid Medical Home initiative will provide incentive payments to Clinics meeting "medical home" standards established by the Department. Those standards will be consistent with the National Committee for Quality Assurance's Physician Practice Connections® - Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program. Clinics achieving NCOA PPC®-PCMH™ recognition will be eligible for incentive payments for providing services to Medicaid FFS patients.

Per visit incentive payments will be made to Clinics that meet the Department standards for certification as a patient centered medical homes, consistent with the NCOA PPC®-PCMH™ Program. There are three levels of "medical home" recognition: Levels 1, 2 and 3. Eligible Clinics will receive a per visit incentive payment commensurate with their level of "medical home" recognition. Incentive payments will be added to claims from NCOA recognized Clinics for visits with evaluation and management codes identified by the Department as "primary care."

To determine appropriate incentive payment amounts, the NY Medicaid Program conducted a review of "medical home" incentive payments nationally. Most programs paid medical home incentive payments on a per member per month (PMPM) basis. To work in the fee-for-service payment context, PMPM benchmark amounts used by

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programs in several other states (\$2, \$4, and \$6) were converted to per-visit payment amounts by first multiplying the PMPM payment by twelve (12) to calculate an annual per member payment, and then dividing the annual amount by the average number of annual primary care visits to general hospitals providing outpatient care, free standing diagnostic and treatment centers, and Federally Qualified Health Centers to arrive at a per-visit incentive payment amount for each level of medical home recognition.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as patient centered medical homes. The agency's fee schedule rates were set as of December 1, 2009 and are effective for services provided on or after that date. All rates are published on the State Department of Health's website.

The "medical home" recognition for clinics is site-specific. Once a Clinic advances to a higher level of "medical home" designation it will no longer be eligible for the lower level incentive payment per Evaluation and Management visit. A Clinic may only receive one level of incentive payment at a time for each eligible visit. Medical home incentive payments are only applicable to claims when Medicaid is the primary payer.

To maintain eligibility for incentive payments, Clinics must: (a) renew their "patient centered medical home" certification at a frequency determined by the Commissioner; and (b) provide data to the Department to permit the Commissioner to evaluate the impact of patient centered medical homes on quality, outcomes and cost.

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**Adirondack Medical Home Multipayor Program -- Freestanding Clinics**

Effective for periods on and after December 1, 2009, the Commissioner of Health is authorized to certify certain clinicians and clinics in the upper northeastern region of New York as health care homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for services provided to recipients eligible for Medicaid fee-for-service; enrollees eligible for Medicaid managed care; and enrollees eligible for and enrolled in Family Health Plus organizations pursuant to Title 11-D of Article 28 of the Public Health Law (PHL).

Clinic shall mean a general hospital providing outpatient care or a free-standing diagnostic and treatment center licensed under Article 28 of the Public Health Law that is designated as a Federally Qualified Health Center pursuant to Section 1861(aa) of the Social Security Act.

The Adirondack Medical Home Multipayor Program is a primary care medical home collaborative of health care service providers including hospitals, diagnostic and treatment centers and private practices serving residents and eligible recipients in the counties of Clinton, Essex, Franklin, Hamilton, Saratoga and Warren. Incentive payments to clinics that meet "medical home" standards will be established jointly by the State Department of Health, participating health care service providers and payors. Medical home certification includes, but is not limited to, existing standards developed by national accrediting and professional organizations, including the National Committee for Quality Assurance's (NCQA) Physician Practice Connections® - Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program.

Under this program, incentive payments will be made for one year to participating providers to support conversion of these clinic practices to certified medical homes. Within one year, providers in the Multipayor Program, must achieve either Level 2 or Level 3 including additional criteria (referred to as Level 2 Plus and Level 3 Plus) as determined by the program participants. Eligible providers will receive the same incentive payment commensurate with the following levels of "medical home" designation: conversion support; Level 2 Plus; or Level 3 Plus. There will be no incentive payment for Level 1 designation. Incentive payments will be added to claims from program clinics for visits with Evaluation and Management codes identified by the Department of Health as "primary care."

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The incentive amount was determined by the Department of Health and participating payors based on a market analysis of the cost to support the conversion of a practice to provide "medical home" patient care and management information systems related to meeting the objectives of this initiative. The participating payors agreed to a per member per month (PMPM) incentive payment of \$7. To calculate the per-visit incentive payment amount, the PMPM was multiplied by twelve (12) to calculate an annual per member payment (\$84) and then this annual amount was divided by the average number of annual primary care visits to clinics and practitioners' offices to arrive at a per visit incentive payment. The average annual visit rate, based on two years of claims data (January 1, 2007 - December 31, 2008) for a specific list of providers who agreed to participate in the Multipayor Program, was 3 visits per year. Therefore, the per visit incentive payment is \$28. The incentive amount will be approved by the Division of the Budget.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of primary care "medical home" services in the Multipayor Program. The agency's fee schedule rate was set as of December 1, 2009 and is effective for services on or after that date. All Medicaid rates are published on the Department of Health's public website.

Patient and health care services participation in the Adirondack Medical Home Multipayor Program is on a voluntary basis. While clinics and clinicians are participating in the Multipayor Program, they are precluded from receiving incentive payments under the statewide patient centered medical home program established pursuant to section 364-m of the Social Services Law.

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**Statewide Patient Centered Medical Home – Federally Qualified Health Centers**

Effective for periods on and after December 1, 2009, the Commissioner of Health is authorized to certify certain clinics as patient centered medical homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for services provided to recipients eligible for Medicaid fee-for-service (FFS).

A Federally Qualified Health Center shall mean a general hospital providing outpatient care or a free standing diagnostic and treatment center licensed under Article 28 of the Public Health Law that is designated as a Federally Qualified Health Center pursuant to Section 1861(aa) of the Social Security Act.

To improve access to high quality primary care services, the statewide Medicaid Patient Centered Medical Home initiative will provide incentive payments to Federally Qualified Health Centers that meet "medical home" standards established by the Department. Those standards will be consistent with the National Committee for Quality Assurance's (NCOA) Physician Practice Connections® - Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program. Federally Qualified Health Centers achieving NCOA PPC®-PCMH™ recognition will be eligible for incentive payments for providing services to Medicaid FFS patients.

Per visit incentive payments will be made to Federally Qualified Health Centers that meet the Department standards for certification as a patient centered medical homes, consistent with the NCOA PPC®-PCMH™ Program. There are three levels of "medical home" recognition: Levels 1, 2 and 3. Eligible Federally Qualified Health Centers will receive a per visit incentive payment commensurate with their level of "medical home" recognition. Incentive payments will be added to claims from NCOA recognized Federally Qualified Health Centers for visits with evaluation and management codes identified by the Department as "primary care."

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**Adirondack Medical Home Multipayor Program – Federally Qualified Health Centers (FQHCs)**

Effective for periods on and after December 1, 2009, the Commissioner of Health is authorized to certify certain clinicians and clinics in the upper northeastern region of New York as health care homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for services provided to recipients eligible for Medicaid fee-for-service; enrollees eligible for Medicaid managed care; and enrollees eligible for and enrolled in Family Health Plus organizations pursuant to Title 11-D of Article 28 of the Public Health Law (PHL).

**A Federally Qualified Health Center** shall mean a general hospital providing outpatient care or a free-standing diagnostic and treatment center licensed under Article 28 of the Public Health Law that is designated as a Federally Qualified Health Center pursuant to Section 1861(aa) of the Social Security Act.

The Adirondack Medical Home Multipayor Program is a primary care medical home collaborative of health care service providers including hospitals, diagnostic and treatment centers and private practices serving residents and eligible recipients in the counties of Clinton, Essex, Franklin, Hamilton, Saratoga and Warren. Incentive payments to FQHCs that meet "medical home" standards will be established jointly by the State Department of Health, participating health care service providers and payors. Medical home certification includes, but is not limited to, existing standards developed by national accrediting and professional organizations, including the National Committee for Quality Assurance's (NCQA) Physician Practice Connections® - Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program.

Under this program, incentive payments will be made for one year to participating providers to support conversion of the FQHC practices to certified medical homes. Within one year, providers in the Multipayor Program, must achieve either Level 2 or Level 3 including additional criteria (referred to as Level 2 Plus and Level 3 Plus) as determined by the program participants. Eligible providers will receive the same incentive payment commensurate with the following levels of "medical home" designation: conversion support; Level 2 Plus; or Level 3 Plus. There will be no incentive payment for Level 1 designation. Incentive payments will be added to claims from program FQHCs for visits with Evaluation and Management codes identified by the Department of Health as "primary care."

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The incentive amount was determined by the Department of Health and participating payors based on a market analysis of the cost to support the conversion of a practice to provide "medical home" patient care and management information systems related to meeting the objectives of this initiative. The participating payors agreed to a per member per month (PMPM) incentive payment of \$7. To calculate the per-visit incentive payment amount, the PMPM was multiplied by twelve (12) to calculate an annual per member payment (\$84) and then this annual amount was divided by the average number of annual primary care visits to clinics and practitioners' offices to arrive at a per visit incentive payment. The average annual visit rate, based on two years of claims data (January 1, 2007 – December 31, 2008) for a specific list of providers who agreed to participate in the Multipayor Program, was 3 visits per year. Therefore, the per visit incentive payment is \$28. The incentive amount will be approved by the Division of the Budget.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of primary care "medical home" services in the Multipayor Program. The agency's fee schedule rate was set as of December 1, 2009 and is effective for services on or after that date. All Medicaid rates are published on the Department of Health's public website.

Patient and health care services participation in the Adirondack Medical Home Multipayor Program is on a voluntary basis. While FQHCs are participating in the Multipayor Program, they are precluded from receiving incentive payments under the statewide patient centered medical home program established pursuant to section 364-m of the Social Services Law.

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**Freestanding Clinic Services (diagnostic and treatment facilities) Facilities Certified Under Article 28 of the State Public Health Law**

Prospective, all inclusive rates calculated by Department of Health, based on the lower of the allowable average cost per visit or the group ceiling trended to the current year. For purposes of establishing rates of payment for diagnostic and treatment centers for services provided on or after April 1, 1995 through March 31, 1999, and on or after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31 2003, and on and after April 1, 2003 through March 31, [2007] 2009, the reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Facilities offering similar types of services and having similar regional economic factors are grouped and ceilings are calculated on the cost experience of facilities within the group taking into account regional economic factors such as geographic location. Costs at or below these ceilings have been determined to be reasonable. The facility-specific impact of eliminating the statewide cap on administrative and general costs, for the period April 1, 1999 through June 30, 1999 shall be included in rates of payment for facilities affected by such elimination for the period October 1, 1999 through December 31, 1999.

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The rates include a capital cost component. For fiscal year ending March 31, 1994, such rates are trended and extended to September 30, 1994. Commencing October 1, 1994 and thereafter, such rates shall be calculated as above for fiscal years beginning October 1, and ending September 30 except that rates of payment for the period ending September 30, 1995, shall continue in effect through September 30, [2007] 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. For the period October 1, 2004 through December 31, 2004, freestanding clinic MMTP services shall be reimbursed on a uniform weekly fee per enrolled patient at the rate of \$173.13. For the period beginning on January 1, 2005 and thereafter, the uniform fixed weekly fee for MMTP services will equal 100% of the weekly rate for hospital based MMTP service providers. Payment rates for renal dialysis services of \$150.00 per procedure are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. A single price per visit for day health care services rendered to patients with acquired immunodeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses is determined based on reasonable projections of necessary costs and utilization and trended to later rate years. Price components may be adjusted for service capacity, urban or rural location and regional differences. Rates are subject to approval of the Division of the Budget.

**Additional Funding for Diagnostic and Treatment Centers for the period October 1, 1999 through December 31, 1999**

Rates for diagnostic and treatment centers for the period October 1, 1999 through December 31, 1999 shall include, in the aggregate, the sum of fourteen million dollars (\$14,000,000) which shall be added to rates of payment based on an apportionment of such amount using a ratio of each individual provider's estimated Medicaid expenditures to total estimated Medicaid expenditures for diagnostic and treatment centers, as determined by the Commissioner, for the October 1, 1999 through September 30, 2000 rate period.

**Additional Funding for Diagnostic and Treatment Centers Providing Services to Persons With Developmental Disabilities**

For the period July 1, 2000, through March 31, 2001 and annual state fiscal periods thereafter, fee-for-service rates of payment for medical assistance services provided to patients eligible for federal financial participation under title XIX of the federal social security act by diagnostic and treatment centers licensed under article 28 of the public health law that provide services to individuals with developmental disabilities as their principal mission, shall be increased by

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annual amounts of two million two hundred eighty thousand dollars (\$2,280,000) in the aggregate. Each such diagnostic and treatment center shall receive a proportionate share of these funds based upon the ratio of its medical assistance units of service to the total medical assistance units of service of all such facilities during the base year. The base year shall be the calendar year immediately proceeding each annual period. There shall be no reconciliation of the amount added to rates of payment pursuant to this section to reflect the actual number of Medicaid units of service for affected providers for the period July 1, 2000 to March 31, 2001 and annual state fiscal periods thereafter.

**Facilities Certified Under Article 28 of the Public Health Law As Freestanding Diagnostic and Treatment Centers**

**Services for medically supervised chemical dependence treatment and medically supervised withdrawal services**

For dates of service beginning on July 1, 2002, facilities providing these services shall be reimbursed at their existing rate for provision of comprehensive diagnostic and treatment center services as described in the paragraphs of the section of this plan titled Freestanding Clinic Services (diagnostic and treatment facilities) Facilities Certified Under Article 28 of the State Public Health Law; Including Federally Qualified Health Centers.

**Designated Preferred Primary Care Provider for Freestanding Diagnostic and Treatment Centers**

Freestanding Diagnostic and treatment centers seeking reimbursement as designated preferred primary care providers are required to enter into a provider agreement with the New York State Department of Health.

Reimbursement for providers designated as preferred primary care providers is prospective and associated with resource use patterns to insure that ambulatory services are economically and efficiently provided. The methodology is based upon the Products of Ambulatory Care (PAC) classification system.

Under the reimbursement method, facility specific payment rates are established for each of the PAC groups. For each service a rate is established to cover all labor, ancillary services, medical supplies, administrative overhead, general and capital costs. A supplemental capital add-on is available to facilities participating in the preferred primary care program which finance capital acquisitions through public authorities. The per visit rate add-on is calculated by dividing the related capital cost by current patient visit volume.

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The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor, except that rates of payment for the period ending September 30, 1995, shall continue in effect through September 30, [2007] 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate. A supplemental bad debt and charity care allowance will be established annually for diagnostic and/or treatment centers approved as preferred primary care providers and paid as an addition to the facility's rate of payment. Each facility's allocation shall be based on its losses associated with the delivery of bad debt and charity care and computed on the basis of projected and allowable fiscal and statistical data, adjusted to actual, submitted by the facility. The amount paid per visit shall be based on each facility's allocation divided by projected Medicaid threshold visits adjusted to actual visits. This supplemental bad debt and charity care allowance shall be in effect until December 31, 1996.

For services provided on or after April 1, 1995, by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994, based on the reimbursement payment methodology described in this section, or by a diagnostic and treatment center operated by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995, for designation as a preferred primary care provider. The reimbursement payment methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating diagnostic and treatment centers. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.

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**Ambulatory Patient Group System**

For dates of service beginning December 1, 2008, for hospital outpatient clinic and ambulatory surgery services, and beginning January 1, 2009, for emergency department services, through March 31, 2010, the operating component of rates for hospital based outpatient services shall be reimbursed using a methodology that is prospective and associated with resource utilization to ensure that ambulatory services are economically and efficiently provided. The methodology is based upon the Ambulatory Patient Group (APG) classification and reimbursement system. This methodology incorporates payments for the separate covered Medicaid benefits in accordance with the payment methods for these services. Reimbursement for the capital component of these rates shall be made as an add-on to the operating component as described on Page 1(k) of this section.

The Ambulatory Patient Group patient classification system is designed to explain the amount and type of resources used in an ambulatory visit by grouping patients with similar clinical characteristics and similar resource use into a specific APG. Each procedure code associated with a patient visit is assigned to an APG using the grouping logic developed by 3M Health Information Systems. When evaluation and management codes are coded, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

**The following is a list of definitions relating to the Ambulatory Patient Group reimbursement system.**

**Allowed APG Weight** shall mean the relative resource utilization for a given APG after adjustment for bundling, packaging, and discounting.

**Ambulatory Patient Group (APG)** shall mean a group of outpatient procedures, encounters or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of ICD-9-CM diagnosis and HCPCS procedure codes, as defined below. APG are defined under 3M Health Information Systems' grouping logic outlined in the APG Definitions Manual version 3.1 dated March 6, 2008 and as subsequently amended by 3M;

**APG Relative Weight** shall mean a numeric value that reflects the relative expected average resource utilization (cost) for each APG as compared to the expected average resource utilization for all other APGs.

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APG Software shall mean the New York State-specific version of the APG computer software developed and published by (3M) Health Information Systems, Inc. (3M) to process HCPCS/CPT-4 and ICD-9-CM code information in order to assign patient visits, at the procedure code level, to the appropriate APGs and apply appropriate bundling, packaging, and discounting logic to in turn calculate the final APG weight and allowed reimbursement for a patient visit. Each time the software is updated, 3M HIS will automatically send updated software to all license holders. Providers and other interested parties that do not purchase the grouper software, can perform the computations by accessing the APG definitions manual, which is available on the 3M web site.

Base Rate shall mean the dollar value that shall be multiplied by the allowed APG weight for a given APG, or by the final APG weight for each APG on a claim to determine the total allowable Medicaid operating payment for a visit.

Case Mix Index is the actual or estimated average final APG weight for a defined group of APG visits.

Coding Improvement Factor is a numeric value used to adjust for more complete and accurate coding for visits upon implementation of the APG reimbursement system. The current coding improvement factors are 1.05 for emergency department, 1.085 for outpatient hospital, and 1.01 for ambulatory surgery.

Consolidation/Bundling shall mean the process for determining if a single payment amount is appropriate in those circumstances when a patient receives multiple APG procedures during a single patient visit. In some cases, a procedure will be considered part of a more complicated procedure. In this case the payment for the less complicated procedure will be included in the payment for the more complicated procedure and the claim line for the less complicated procedure will show zero payment for that procedure. Consolidation logic is defined in the 3M Health Information Systems' APG Definitions Manual version 3.1 dated March 6, 2008 and as subsequently amended by 3M;

Current Procedural Terminology-fourth edition (CPT-4) is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. It is a subset of the Healthcare Common Procedure Coding System (HCPCS). The CPT-4 is maintained by the American Medical Association and HCPCS are maintained by the Centers for Medicare and Medicaid Services. Both coding systems are updated annually.

Discounting shall mean the reduction in APG payment that results when related procedures or ancillary services are performed during a single patient visit.

Final APG Weight shall mean the allowed APG weight for a given visit as calculated by the APG software using the logic in the APG definitions manual, including all adjustments applicable bundling, packaging, and discounting.

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"HCPCS Codes" are from the Healthcare Common Procedure Coding System, a numeric coding system maintained by the Centers for Medicare and Medicaid Services (CMS) and used to identify services and procedures for purposes of billing public or private health insurance programs. CPT (Common Procedure Terminology) codes are a subset of the HCPCS coding system.

International Classification of Diseases, 9th Revision-Clinical Modification (ICD-9-CM) is a comprehensive coding system maintained by the federal Centers for Medicare and Medicaid Services in the US Department of Health and Human Services. It is maintained for the purpose of providing a standardized, universal coding system to identify and describe patient diagnosis, symptoms, complaints, condition and/or causes of injury or illness. It is updated annually.

Packaging shall mean those circumstances in which payment for routine ancillary services or drugs shall be deemed as included in the applicable APG payment for a related significant procedure or medical visit. There is no packaging logic that resides outside the software.

"Peer Group" shall mean a group of providers or services that share a common APG base rate. Peer groups may be established based on a geographic region, service type, or categories of patients. The six hospital peer groups are outpatient department - upstate, outpatient department - downstate, ambulatory surgery - upstate, ambulatory surgery - downstate, emergency department - upstate, and emergency department - downstate.

"Region" shall mean the counties constituting a peer group that has been defined, at least in part, on a regional basis. The downstate region shall consist of the five counties comprising New York City, as well as the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The upstate region shall consist of all other counties in New York State.

"Visit" shall mean a unit of service consisting of all the APG services performed for a patient on a single date of service, provided, however, that services provided in an emergency department which extend into a second calendar date may be treated as one visit for reimbursement purposes.

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**Reimbursement Methodology**

- I. The initial calculation of the APG relative weights were developed using line level charges from 2005 New York Medicaid claims converted to cost using the ratio of cost to charges methodology. The line level costs were brought up to the APG level to determine the average cost of each APG.

The APG relative weights shall be updated at least annually. These APG and weights are set as of December 1, 2008, and are effective for specified services on and after that date. The APG's and their relative weights are published on the NYS Department of Health website at: [http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/docs/proposed\\_regulations.pdf](http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/proposed_regulations.pdf)

- a. The APG relative weights shall be reweighted prospectively. The initial reweighting will be based on Medicaid claims data from the December 1, 2008 through April 30, 2009, period. Subsequent reweightings will be based on Medicaid claims data from the most recent twelve month period and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.
- b. The Department shall correct material errors of any given APG relative weight. Such corrections shall make use of benchmarking data consisting of payment information from other payers (including Medicare) reimbursing comparable services. Corrections to material errors in individual APG relative weights shall be made on a prospective basis.

- II. Case mix index is an expression of the average paid APG weight for a given peer group after consolidation, packaging, and discounting. Case mix indices shall be calculated by running applicable claims data through the latest version of the APG software to determine the average final APG weight of the visits. Outlier claims or claim lines may be excluded from this calculation to assure overall accuracy of the final case mix. The initial recalculation of case mix indices will be based on Medicaid data from the December 1, 2009, through April 30, 2009, period. Subsequent recalculations will be based on Medicaid claims data from the most recent twelve month period.

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III. The APG base rates shall be updated at least annually. The initial update will be based on claims data from the December 1, 2008 through April 30, 2009 period, and subsequent updates will be based on Medicaid claims data from the most recent twelve month period, and will be based on complete and accurate billing data. APG base rates shall be rebased each time the APG relative weights are reweighted.

a. If it is determined by the Department that an APG base rate is materially incorrect, the Department shall correct that base rate prospectively so as to align aggregate reimbursement with total available funding. APG payments shall also reflect an investment of \$178 million on an annualized basis. The case mix index shall be calculated using 2005 claims data.

IV. For the period December 1, 2008 to December 31, 2009, the APG base rates shall be calculated using the total operating reimbursement and the associated number of visits for services moving to APG reimbursement for the period January 1, 2007 to December 31, 2007. APG payments shall also reflect an investment of \$178 million on an annualized basis. The case mix index shall be calculated using 2005 claims data.

- a. For all rate periods subsequent to December 31, 2009, estimated total operating reimbursement and the estimated number of visits shall be calculated based on historical claims data. The initial reestimation will be based on claims data from the December 1, 2008 through April 30, 2009 period, and subsequent reestimations will be based on Medicaid claims data from the most recent twelve month period, and will be based on complete and accurate data.
- b. The estimated case mix index shall be calculated using the appropriate version of the 3M APG software based on claims data. The initial reestimation will be based on claims data from the December 1, 2008 through April 30, 2009 period, and subsequent reestimations will be based on Medicaid claims data from the most recent twelve month period, and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

V. Rates for new facilities during the transition period

- (1) General hospital outpatient clinics which commence operation after December 31, 2007, and prior to January 1, 2012, and for which rates computed pursuant to Public Health Law §2807(2) are not available shall have the capital cost component of their rates based on a budget as submitted by the facility and as approved by the Department and shall have the operating component of their rates computed in accordance with the following:
- (2) For the period December 1, 2008 through December 31, 2009, 75% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 25% of such rates shall reflect APG rates as computed in accordance with this Subpart:

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- (3) for the period January 1, 2010 through December 31, 2010, 50% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 50% of such rates shall reflect APG rates as computed in accordance with this Subpart;
- (4) for the period January 1, 2011 through December 31, 2011, 25% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 75% of such rates shall reflect APG rates as computed in accordance with this Subpart;
- (5) for periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this Subpart.
- (6) for the purposes of this subdivision, the historical 2007 regional average payment per visit shall mean the result of dividing the total facility specific Medicaid reimbursement paid for general hospital outpatient clinic claims paid in the 2007 calendar year in the applicable upstate or downstate region for all rate codes reflected in the APG rate-setting methodology except those specifically excluded pursuant to §86-8.10 of this Subpart, divided by the total visits on claims paid under such rate codes.
- (7) The phase-in described in the preceding paragraphs (2) through (5) is also applicable to hospital based outpatient clinics in operation prior to January 1, 2008.

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**APG Rate Computation**

The following is a description of the methodology to be utilized in calculating rates of payment under the Ambulatory Patient Group classification and reimbursement system.

- I. Claims containing ICD-9-CM diagnostic and CPT-4 procedure codes are submitted to the Department on appropriate forms or in the accepted electronic format.
- II. Claims are reviewed electronically to assign each valid procedure code to the appropriate APG using the APG software logic. Invalid codes will be assigned to an error APG and not given further consideration in the payment process.
- III. Each valid APG on the claim is assigned a relative weight. At this time the software logic also determines an allowed weight based upon whether each APG on the claim is to be paid in full, packaged, consolidated, or discounted.
- IV. The allowed weights for each valid APG on the claim are then summed to arrive at the final weight for this claim. This final weight is multiplied by an operating base rate that is specific to the peer group to which the claim has been assigned resulting in the APG operating cost reimbursement amount for this claim. For hospital outpatient and emergency services, capital will continue to be paid as an add-on using the existing, previously approved methodology. The capital cost component for ambulatory surgery services shall be the result of dividing the total amount of capital cost reimbursement paid to such facilities pursuant to the current Products of Ambulatory Surgery (PAS) system for the 2005 calendar year for the Upstate Region and for the Downstate Region and then dividing each such regional total amount by the total number of claims paid through the PAS system within each such region for the 2005 calendar year.
- V. A separate base rate calculation shall be calculated for each peer group established by the Department. All Medicaid reimbursement paid to facilities for services moving to the APG reimbursement system (e.g., outpatient department, ambulatory surgery, and emergency department services) during the 2007 calendar year will be added to an investment of \$178 million on an annualized basis to form the numerator. The peer group specific case mix index multiplied by the coding improvement factor and the 2007 base year visits will form the denominator resulting in a base rate for that peer group..

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The following is an example of a sample APG base rate calculation:

a. <u>2007 Peer Group Reimbursement</u>	<u>\$51,000,000</u>
b. <u>Additional Investment</u>	<u>\$25,000,000</u>
c. <u>Case Mix Index</u>	<u>8.1610</u>
d. <u>Coding Improvement Factor</u>	<u>1.05</u>
e. <u>2007 Base Year Visits</u>	<u>50,000</u>

$$(\$51,000,000 + \$25,000,000) / (8.1610 \times 1.05 \times 50,000) = \$177.38 \text{ (Base Rate)}$$

VI. During the transition period, reimbursement for hospital based outpatient department services shall consist of a blend of each facility's average 2007 Medicaid rate and the APG calculation for that visit. The average 2007 Medicaid rate for purposes of blending is computed by dividing the amount paid in calendar year 2007 for all rate codes reflected in the APG rate setting methodology, by the total visits paid through those codes for the same time period. In the initial phase (ending December 31, 2009) 25% of the operating payment for each visit will be based upon the APG reimbursement methodology and 75% will be based upon the provider specific average operating payment for calendar year 2007. During 2010, the blend will be 50/50. During 2011, the blend will be 75/25. Hospital outpatient department payments will be based upon 100% of the APG operating component beginning on January 1, 2012. Both the emergency department and ambulatory surgery services will move to 100% APG payment upon implementation with no transition period. Per the enabling statute, as new services the Education APGs and the Extended Hours APGs are not subject to the blend requirement.

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The following shall be excluded from the APG reimbursement system:

- Drugs and other pharmaceutical products and implantable family planning devices for which separate and distinct outpatient billing and payment were authorized by the Department as of December 31, 2007, and as set forth by the Department in written billing instructions issued to providers.
- HIV counseling and testing visits, HIV counseling (no testing), post-test HIV counseling visits (positive results), day health care service (HIV).
- TB/directly observed therapy - downstate levels 1 and 2, TB/directly observed therapy, Upstate levels 1 and 2, AIDS clinic therapeutic visits in general hospital outpatient clinics.
- Child rehabilitation services provided under rate code 2887 in general hospital outpatient clinics.
- Medicaid obstetrical and maternity services (MOMS) provided under rate code 1604.
- Visits solely for the purpose of receiving ordered ambulatory services.
- Visits solely for the purpose of receiving pharmacy services.
- Visits solely for the purpose of receiving education or training services, except with regard to services authorized pursuant to clause (A) of subparagraph (ii) of paragraph (f) of subdivision 2-a of §2807 of the Public Health Law.
- Visits solely for the purpose of receiving services from licensed social workers, except with regard to psychotherapy services provided by Federally Qualified Health Centers or Rural Health Centers choosing to participate in the APG system, or as authorized pursuant to clauses (C) and (D) of subparagraph (ii) of paragraph (f) of subdivision 2-a of §2807 of the Public Health Law.
- Visits solely for the purpose of receiving group services, except with regard to clinical group psychotherapy services provided by Federally Qualified Health Centers or Rural Health Centers choosing to participate in the APG system and provided, however, that reimbursement for such group services shall be determined in accordance with state regulation.
- Offsite services, defined as medical services provided by a facility's outpatient staff at locations other than those operated by and under the facility's licensure under Article 28 of the Public Health Law, or visits related to the provision of such offsite services, except with regard to offsite services provided by Federally Qualified Health Centers or Rural Health Centers.

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The following APGs shall not be eligible for reimbursement through the APG system:

065 RESPIRATORY THERAPY  
066 PULMONARY REHABILITATION  
094 CARDIAC REHABILITATION  
117 HOME INFUSION  
118 NUTRITION THERAPY  
190 ARTIFICIAL FERTILIZATION  
311 FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE  
312 FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS  
313 HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE  
314 HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS  
319 ACTIVITY THERAPY  
320 CASE MANAGEMENT – MENTAL HEALTH OR SUBSTANCE ABUSE  
371 ORTHODONTICS  
427 BIOFEEDBACK AND OTHER TRAINING  
430 CLASS I CHEMOTHERAPY DRUGS  
431 CLASS II CHEMOTHERAPY DRUGS  
432 CLASS III CHEMOTHERAPY DRUGS  
433 CLASS IV CHEMOTHERAPY DRUGS  
434 CLASS V CHEMOTHERAPY DRUGS  
450 OBSERVATION  
452 DIABETES SUPPLIES  
453 MOTORIZED WHEELCHAIR  
454 TPN FORMULAE  
456 MOTORIZED WHEELCHAIR ACCESSORIES  
492 DIRECT ADMISSION FOR OBSERVATION INDICATOR  
500 DIRECT ADMISSION FOR OBSERVATION – OBSTETRICAL  
501 DIRECT ADMISSION FOR OBSERVATION – OTHER DIAGNOSES  
999 UNASSIGNED

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The following APGs shall not be eligible for reimbursement when they are presented as the only APG or APGs applicable to a patient visit or when the only other APGs presented with them are one or more of the APGs listed in the list of APGs not eligible for reimbursement:

- 280 VASCULAR RADIOLOGY EXCEPT VENOGRAPHY OF EXTREMITY
- 284 MYELOGRAPHY
- 285 MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST
- 286 MAMMOGRAPHY
- 287 DIGESTIVE RADIOLOGY
- 288 DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL AND VASCULAR OF LOWER EXTREMITIES
- 289 VASCULAR DIAGNOSTIC ULTRASOUND OF LOWER EXTREMITIES
- 290 PET SCANS
- 291 BONE DENSITOMETRY
- 298 CAT SCAN - BACK
- 299 CAT SCAN - BRAIN
- 300 CAT SCAN - ABDOMEN
- 301 CAT SCAN - OTHER
- 302 ANGIOGRAPHY, OTHER
- 303 ANGIOGRAPHY, CEREBRAL
- 330 LEVEL I DIAGNOSTIC NUCLEAR MEDICINE
- 331 LEVEL II DIAGNOSTIC NUCLEAR MEDICINE
- 332 LEVEL III DIAGNOSTIC NUCLEAR MEDICINE
- 380 ANESTHESIA
- 390 LEVEL I PATHOLOGY
- 391 LEVEL II PATHOLOGY
- 392 PAP SMEARS
- 393 BLOOD AND TISSUE TYPING
- 394 LEVEL I IMMUNOLOGY TESTS
- 395 LEVEL II IMMUNOLOGY TESTS
- 396 LEVEL I MICROBIOLOGY TESTS
- 397 LEVEL II MICROBIOLOGY TESTS
- 398 LEVEL I ENDOCRINOLOGY TESTS
- 399 LEVEL II ENDOCRINOLOGY TESTS
- 400 LEVEL I CHEMISTRY TESTS
- 401 LEVEL II CHEMISTRY TESTS
- 402 BASIC CHEMISTRY TESTS
- 403 ORGAN OR DISEASE ORIENTED PANELS
- 404 TOXICOLOGY TESTS
- 405 THERAPEUTIC DRUG MONITORING

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406 LEVEL I CLOTTING TESTS  
407 LEVEL II CLOTTING TESTS  
408 LEVEL I HEMATOLOGY TESTS  
409 LEVEL II HEMATOLOGY TESTS  
410 URINALYSIS  
411 BLOOD AND URINE DIPSTICK TESTS  
413 CARDIOGRAM  
414 LEVEL I IMMUNIZATION AND ALLERGY IMMUNOTHERAPY  
415 LEVEL II IMMUNIZATION  
416 LEVEL III IMMUNIZATION  
435 CLASS I PHARMACOTHERAPY  
436 CLASS II PHARMACOTHERAPY  
437 CLASS III PHARMACOTHERAPY \  
438 CLASS IV PHARMACOTHERAPY  
439 CLASS V PHARMACOTHERAPY  
451 SMOKING CESSATION TREATMENT  
455 IMPLANTED TISSUE OF ANY TYPE  
457 VENIPUNCTURE  
470 OBSTETRICAL  
471 PLAIN FILM  
472 ULTRASOUND GUIDANCE  
473 CT GUIDANCE

**System updating**

The following elements of the APG reimbursement system shall be updated no less frequently than annually:

- the listing of reimbursable APGs and the relative weight assigned to each APG;
- the base rates;
- the applicable ICD-9-CM codes utilized in the APG software system;
- the applicable CPT-4/HCPCS codes utilized in the APG software system; and
- the APG software system.

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[responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.]

**Ordered Ambulatory Services (specific services performed by a free-standing clinic on an ambulatory basis upon the order of a qualified physician, physician's assistant, dentist or podiatrist to test, diagnose or treat a recipient or specimen taken from a recipient).**

Fee schedule developed by the Department of Health and approved by the Division of the Budget for each type of service, as appropriate. Payment for these services are in compliance with 42 CFR 447.325.

**AIDS/HIV Adult Day Health Care Services For Diagnostic And Treatment Centers**

Medical assistance rates of payment for adult day health care services provided on and after December 1, 2002 to patients with AIDS/HIV by a free standing ambulatory care facility shall be increased by three percent.

This increase to rates of payment will be for purposes of improving recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Programs are prohibited from using the funds for any other purpose. The Commissioner of Health is authorized to audit each program to ensure compliance with the purpose for which this funding is provided and shall recoup any funds determined to have been used for purposes other than recruitment and retention.

To generate a threshold day care bill, the provider must ensure that clients receive a core service and be in attendance for a minimum of three hours, and over the course of the week, receive a minimum of three hours of health care services. Health care services are defined as both the core services and health related services that are therapeutic in nature and directly or indirectly related to the core services, which must be identified on the client's comprehensive care plan. Each visit must include a core service. A bill cannot be generated if these two requirements are not met.

**Core services include:**

- Medical visits
- Nursing visits

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- Individual and group Mental Health services
- Individual and group Nutrition counseling services
- Individual and group Substance Abuse counseling services
- Medication group counseling
- Activities of Daily Living
- Physical and Occupational Therapy services
- Case management services
- Prevention/Risk reduction counseling
- Any routine assessment performed by an appropriately credentialed staff person

**Health related (non-core) services include:**

- Group exercise sessions
- Acupuncture
- Breakfast and/or lunch
- Therapeutic massage
- Yoga
- Pastoral care
- Therapeutic recreation and structured socialization services
- Tai-chi

For adult day health care services provided on and after January 1, 2007, medical assistance rates of payment to diagnostic and treatment centers shall be increased up to an annual amount of \$2.8 million in the aggregate. Such amount shall be allocated proportionally among eligible providers based on the medical assistance visits reported by each provider in the most recently available cost report, as submitted to the Department of Health. Such allocated amounts will be included as an adjustment to each provider's daily rate of payment for such services.

Effective for adult day health care services rendered on and after January 1, 2007 through December 31, 2009, and for adult day health care services provided to patients diagnosed with AIDS on and after April 1, 2009, medical assistance rates of payments shall reflect trend factor adjustments computed in accordance with the previously approved trend factor methodology. Such adjustments shall be applied to the operational cost component of the rate.

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**Hospital Based Ambulatory Surgery Facilities Certified Under Article  
28 of the Public Health Law**

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, space occupancy, and plant over-head costs. An economic trend factor is applied to make the prices prospective. Rates of payment in effect on March 31, 2003, shall continue in effect for the period April 1, 2003 through [September 30, 2007] March 31, 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate.

**Freestanding-Diagnostic and Treatment Centers**

**Facilities Certified Under Article 28 of the Public Health Law as  
Freestanding Ambulatory Surgery Centers**

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, space occupancy, and plant over-head costs. An economic trend factor is applied to make the prices prospective. Rates in effect on March 31, 2003, shall continue in effect for the period April 1, 2003 through [September 30, 2007] March 31, 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate. The agency may pay the usual and customary rates of such medical facilities or approved services but must not pay more than the prevailing rates for comparable services in the geographic area.

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**Hospital Based Outpatient Department**

**Facilities Certified Under Article 28 of the Public Health Law**

**Services for AIDS and HIV positive patients**

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective. For dates of service beginning on December 1, 2008 through March 31, 2010, the discrete services for comprehensive initial visit, post-test HIV counseling (negative result), and monitoring – asymptomatic HIV disease shall be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

**Freestanding Diagnostic and Treatment Centers**

**Facilities Certified Under Article 28 of the Public Health Law As Freestanding Diagnostic and Treatment Centers**

**Services for AIDS and HIV positive patients**

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, [2007] 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate.

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**Hospital Based Outpatient Department**

**Facilities Certified Under Article 28 of the Public Health Law**

**Services for medically supervised chemical dependence treatment and medically supervised withdrawal services**

For dates of service beginning on July 1, 2002, for those facilities certified under Article 28 of the State Public Health Law, the Department of Health promulgates prospective, all-inclusive rates based upon reported historical costs. Allowable operating costs per visit are held to legislatively established ceiling limitations. Reported historical operating costs on a per visit basis, which are below or limited by ceilings, are deemed reimbursable and trended forward to the current rate period to adjust for inflation. Non-operating costs (such as capital costs) are not subject to the legislatively established ceiling and are added to the product of reimbursable operating costs times the roll factor (two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, [2007] 2009, for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, shall be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of \$67.50 per visit.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

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**Hospital Based Outpatient Department**

**Facilities Certified Under Article 28 of the Public Health Law as Hospital-Based Outpatient Departments**

**Services for Pregnant Women**

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women, for each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, minus 0.25%.

Effective for services provided on and after January 1, 2007 and April 1 of each state fiscal year thereafter, the Commissioner of Health shall adjust prenatal care assistance program rates to effect a cost of living adjustment (COLA). This COLA will be calculated in accordance with the general Trend Factor section of in this Attachment.

**Freestanding Diagnostic and Treatment Centers**

**Facilities Certified Under Article 28 of the Public Health Law as Freestanding Diagnostic and Treatment Centers**

**Services for Pregnant Women**

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, [2007] 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate.

TN           #07-06          

Approval Date           OCT 18 2010          

Supersedes TN           #06-64          

Effective Date           APR 01 2007

**OFFICIAL**

New York  
2(c)(i)

Attachment 4.19-8  
SPA #03-32  
(07/03)

**Comprehensive Primary Care Services**

**Voluntary Non-Profit and Publicly Sponsored Diagnostic and Treatment Centers Certified Under Article 28 of the Public Health Law**

An allowance will be established annually and added to Medicaid rates of payment for certified agencies, which can demonstrate a financial shortfall as a result of providing comprehensive primary care services to a disproportionate share of uninsured low-income patients. Losses will be calculated by applying the current Medicaid payment rate to base year units of service to uninsured low-income patients, offset by related-out-of-pocket patient receipts, subsidy grants and State aid deficit financing to publicly-sponsored facilities. An annual agency loss coverage will be established by applying calculated losses to a nominal loss coverage ratio scale within the limits of pool allocations to public and non-public agencies. Notwithstanding any inconsistent provisions of this paragraph, adjustments to rates of payment for diagnostic and treatment centers determined in accordance with this paragraph shall apply only for services provided on or before December 31, 1996.

The methodology described in the following paragraphs pertains to diagnostic and treatment centers, which received an allowance for financing losses resulting from the provision of comprehensive primary care services to a disproportionate share of uninsured low-income patients during the period from July 1, 1990 through December 31, 1996. This allowance is described in the previous paragraph. For the period July 1, 2003 through December 31, 2003, qualified diagnostic and treatment centers shall receive an uncompensated care rate adjustment of not less than one-half the amount that would have been received for any losses associated with the delivery of bad debt and charity care for calendar year 1995.

For the period January 1, 2004 through December 31, 2004, each such diagnostic and treatment center shall receive an uncompensated care rate adjustment of not less than twice the amount calculated pursuant to the above paragraph. For the period January 1, 2005 through June 30, 2005, each such diagnostic and treatment center shall receive an uncompensated care rate adjustment of not less than the amount calculated pursuant to the above paragraph.

Any residual amount allocated for distribution to a classification of diagnostic and treatment centers in accordance with the above shall be reallocated by the Commissioner for distributions to the other classifications based on remaining need.

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New York  
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Attachment 4.19-B  
SPA #03-32  
(07/03)

Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible diagnostic and treatment centers and shall not be subject to subsequent adjustment or reconciliation.

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Supersedes TN NEW Effective Date JUN 01 2003

**OFFICIAL**

**Transitional Supplemental Payments**

For the periods February 1, 2002 through March 31, 2002, October 1, 2002 through December 31, 2002, October 1, 2003 through December 31, 2003, April 1, 2005 through June 30, 2005, October 1, 2006 through December 31, 2006, and October 1, 2007 through December 31, 2007, the Commissioner of Health shall make supplemental medical assistance payments to qualified voluntary not-for-profit health care providers that are: freestanding diagnostic and treatment centers (D&TCs) that qualify for distributions under the state's comprehensive diagnostic and treatment centers indigent care program or indicate on the cost reports submitted to the state that they receive funding under section three hundred thirty-three of the Federal Public Health Services Act for health care for the homeless, freestanding diagnostic and treatment centers that operate approved programs under the state Prenatal Care Assistance Program, or licensed freestanding family planning clinics. These supplemental payments reflect additional costs associated with the transition to Managed Care and are for services rendered to Medicaid beneficiaries for the effective period. Payments made, as adjustments to fee for service rates, shall not be subject to subsequent adjustment or reconciliation. These providers will be eligible to receive a supplemental payment if the following criteria are met. The provider's number of Medicaid visits in the base year (2000) equals or exceeds 25 percent of its total number of visits and its number of visits for Medicaid Managed Care enrollees equals or exceeds three percent of its total number of Medicaid visits during the base year. Providers meeting these criteria shall receive a supplemental payment equal to a proportional share of the total funds available not to exceed fourteen million dollars for the period February 1, 2002 through March 31, 2002, nine million eight hundred twenty-four thousand dollars for the period October 1, 2002 through December 31, 2002, nine million eight hundred twenty-four thousand dollars (\$9,824,000) for the period October 1, 2003 through December 31, 2003, nine million eight hundred twenty-four thousand dollars (\$9,824,000) for the period April 1, 2005 through June 30, 2005, twenty nine million four hundred seventy-two thousand dollars (\$29,472,000) for the period October 1, 2006 through December 31, 2006, and nine million eight hundred twenty-four thousand dollars (\$9,824,000) for the period October 1, 2007 through December 31, 2007. This share shall be based upon the ratio of a provider's visits from medical assistance recipients enrolled in Managed Care during the 2000 base year to the total number of visits to all such qualified providers by medical assistance recipients enrolled in managed care during the base year. These amounts shall be divided by the medical assistance utilization data reported in each provider's annual cost report for the period two years prior to the rate period. The resulting amount will represent the per visit add-on to each eligible provider's fee for service medical assistance rates of payment.

TN #08-40 \_\_\_\_\_

Approval Date FEB 10 2011

Supersedes TN #07-46 \_\_\_\_\_

Effective Date OCT 01 2008

**Electronic Health Record Systems Supplemental Payments**

For the period October 1, 2008 through December 31, 2008, seven million three hundred eighty eight thousand dollars (\$7,388,000) shall be available to eligible covered providers as medical assistance payments for services provided to Medicaid beneficiaries to reflect additional costs associated with the development, training, maintenance, and support of electronic health record systems that meet such standards no later than January 1, 2008, as established by the Commissioner of Health. The State will conduct a survey and perform independent verification. Electronic health records standards are: the exchanging of health information with other computer systems according to national standards; be certified by the Certification Commission for Health Information Technology; be capable of and used for supporting electronic prescribing; and be capable of and used for providing relevant information to the clinicians to assist with decision making. Providers will be eligible to receive a supplemental payment for the period October 1, 2008 through December 31, 2008, if this criterion is met. In addition to meeting the electronic record standards criterion, a provider's number of Medicaid visits for patient care services during the base year must equal or exceed twenty-five percent of its total number of visits for patient care services in the base year or its number of Medicaid visits combined with its number of uninsured visits for patient care services in the base year equals or exceeds thirty percent of its total number of visits for patient care services during the base year. Each qualified provider shall receive a supplemental payment equal to such provider's proportional share of the total funds allocated, based upon the ratio of its visits from Medicaid recipients during the base year to the total number of Medicaid visits to all such qualified providers during the base year. The base year will be two years prior to the rate year, and the Commissioner of Health shall utilize data to determine Medicaid and uninsured visits reported by covered providers on certified 2006 AHCF-1 cost reports submitted to the Department of Health for such base year.

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New York  
2(c)(iii)(a)

**OFFICIAL**

**Attachment 4.19-B  
(10/08)**

**Supplemental Payments - Dental Clinic - February 1, 2002 through March 31, 2002**

Notwithstanding the provisions of the preceding section, for the period February 1, 2002 through March 31, 2002, facilities licensed under article twenty-eight of the public health law that are sponsored by a university or a dental school which has been granted an operating certificate and which provides dental services as its principal mission, shall receive up to five hundred thousand dollars, in the aggregate, for use as supplemental payments pursuant to the preceding section. These funds shall be allocated for distribution to such facilities pursuant to the statutorily defined methodology contained in §364-j-2 of the Social Services Law. Payments may be added to rates of payment or made as aggregate payments to eligible facilities for services rendered to Medicaid beneficiaries for the effective period. Payments made, as adjustments to fee for service rates, shall not be subject to subsequent adjustment or reconciliation.

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# OFFICIAL

New York  
2(c)(iii)(b)

Attachment 4.19-B  
(10/08)

**Supplemental Payments - Dental Clinic - October 1, 2002 through December 31, 2002, October 1, 2003 through December 31, 2003, April 1, 2005 through June 30, 2005, October 1, 2006 through December 31, 2006, and October 1, 2007 through December 31, 2007, and October 1, 2008 through December 31, 2008.**

Notwithstanding the provisions of the first paragraph of this section titled Transitional Supplemental Payments, for the periods October 1, 2002 through December 31, 2002, October 1, 2003 through December 31, 2003, April 1, 2005 through June 30, 2005, October 1, 2006 through December 31, 2006, and October 1, 2007 through December 31, 2007, facilities licensed under article twenty-eight of the Public Health Law that are sponsored by a university or a dental school which has been granted an operating certificate and which provides dental services as its principal mission, shall receive up to two hundred twenty-five thousand dollars in the aggregate for the period October 1, 2002 through December 31, 2002, for the period October 1, 2003 through December 31, 2003, up to two hundred twenty-four thousand dollars in the aggregate, for the period April 1, 2005 through June 30, 2005, up to two hundred twenty-four thousand dollars in the aggregate, for the period October 1, 2006 through December 31, 2006, up to six hundred seventy-two thousand dollars (\$672,000) in the aggregate, and for the period October 1, 2007 through December 31, 2007, up to two hundred twenty-four thousand dollars (\$224,000) in the aggregate; and for the period October 1, 2008 through December 31, 2008, up to two hundred twenty-four thousand dollars (\$224,000) in the aggregate; for use as supplemental payments pursuant to the first paragraph of this section titled Transitional Supplemental Payments. Forty percent of these funds shall be allocated for equal distribution based upon the facilities losses reported from self-pay and free visits multiplied by the facility specific Medicaid payment rate for the applicable year. This amount shall be offset by any payments received from such patients during the applicable period. Sixty percent, plus any funds allocated but not distributed under provisions of the previous sentence, shall be allocated according to the following scale.

% of eligible BD&CC visits to total visits	% of nominal financial loss coverage
up to 15%	50%
15 - 30%	75%
30%+	100%

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New York  
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**Attachment 4.19-B  
(10/08)**

The allocated amounts will be added to rates of payment [s] for eligible facilities for services rendered to Medicaid beneficiaries for the effective periods. These amounts shall be divided by the medical assistance utilization data reported in each provider's annual cost report for the period two years prior to the rate period. The resulting amount will represent the per visit add-on to each eligible provider's fee for service medical assistance rates of payment. Payments made, as adjustments to fee for service rates, shall not be subject to subsequent adjustment or reconciliation.

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New York  
2(c)(iv)

**OFFICIAL**

Attachment 4.19-B  
SPA #04-23  
(10/04)

Prospective Payment System Reimbursement as of 1 January 2001 for Federally Qualified Health Center (FQHCs) and Rural Health Clinics Including FQHCs Located on Native American Reservations and Operated by Native American Tribes or Tribal Organizations Pursuant To Applicable Federal Law And For Which State Licensure Is Not Required

For services provided on and after January 1, 2001 and prior to October 1, 2001, all-inclusive rates shall be calculated by the Department of Health, based on the lower of the facilities' allowable operating cost per visit or the peer group ceiling plus allowable capital cost per visit. The base for this calculation shall be the average of cost data submitted by facilities for both the 1999 and 2000 base years.

For each twelve month period following September 30, 2001, the operating cost component of such rates of payment shall reflect the operating cost component in effect on September thirtieth of the prior period as increased by the percentage increase in the Medicare Economic Index and as adjusted pursuant to applicable regulations to take into account any increase or decrease in the scope of services furnished by the facility.

Supplementary increases in Medicaid rates of payment for these providers which is paid for the purpose of recruitment and retention of non-supervisory workers or workers with direct patient care responsibility, in accordance with the provisions of page 2(c)(vii) of this attachment, are in addition to the standard Medicaid operating cost component calculation. As such, they are not subject to trend adjustments. These supplementary increases shall be in effect through June 30, 2005.

Rates of payments to facilities which first qualify as federally qualified health centers on or after October 1, 2000 shall be computed as above provided, however, that the operating cost component of such rates shall reflect an average of the operating cost components of rates of payments issued to other FQHC facilities during the same rate period and in the same geographic region, and with similar case load, and further provided that the capital cost component of such rates shall reflect the most recently available capital cost data for such facility as reported to the Department of Health. For each twelve-month period following the rate period in which such facilities commence operation, the operating cost components of rates of payment for such facilities shall be computed as described above.

For services provided on or after January 1, 2001, until such time as the new methodology is implemented, facilities shall be paid via the methodology in place as of December 31, 2000. The difference between the two methodologies shall be calculated and the sum shall be paid, on a per visit basis, in the fiscal year immediately following implementation of this new methodology.

For services provided on or after January 1, 2001 by FQHC's participating in managed care, supplemental payments will be made to these FQHC's that will be equal to 100% of the difference between the facilities reasonable cost per visit rate and the amount per visit reimbursed by the managed care plan.

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2(c)(iv)(a)

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Attachment 4.19-B  
(07/08)

Diagnostic and treatment centers eligible for rates of payment as a Federally Qualified or Rural Health Center, which were also certified by the Department of Health as a preferred primary care provider as of December 31, 2000, and receiving rates of payment through the Products of Ambulatory Care reimbursement system as of such date, may elect to continue to be reimbursed via this alternative method of reimbursement. In no event shall rates of payment to these facilities be less than those computed as described on page 2(c)(iv) of this plan.

Effective on and after January 1, 2006, individual and group psychotherapy services provided to Medicaid patients by a licensed psychiatrist, psychologist, clinical social worker or master social worker at Federally Qualified and Rural Health Centers (FQHC/RHC) shall be reimbursed by the Department of Health. As of January 1, 2006, Federally Qualified and Rural Health Centers shall also be reimbursed for the provision of off-site primary care services provided to existing FQHC/RHC patients in need of professional services available at the FQHC/RHC, but, due to the individual's medical condition, are unable to receive the services on the premises of the center. An existing patient is defined as a registered patient with the FQHC/RHC prior to being admitted to the hospital or nursing home or requiring other offsite services. These services, provided by a physician, physician assistant, nurse practitioner, or nurse mid-wife, may be rendered at the off-site location only for the duration of the limiting illness. Rates of payment for group psychotherapy and off-site services shall be calculated by the Department of Health using elements of the Resource Based Relative Value Scale promulgated by the federal Centers for Medicare and Medicaid Services using the following methodology. For each relevant CPT procedure code, the work, practice expense, and malpractice relative value units are multiplied by a regional (upstate and downstate) average geographic cost index (GPCI). The downstate average GPCI is based on the average of Manhattan, New York City & Long Island, and Queens indices. The upstate average GPCI consists of Poughkeepsie and Rest of State indices. These are then summed and multiplied by the conversion factor to arrive at a regional price for each service. Rates of payment for group psychotherapy services shall not include a component for case management services. Rates of payment for individual psychotherapy services shall be made at the general FQHC rate calculated in accordance with the approved methodology contained on Page 2(c)(iv) of this Attachment.

Effective on and after April 1, 2008, rates of payment may be established based on alternative rate-setting methodologies for Federally Qualified and Rural Health Centers provided such methodologies, contained on plan pages 1(f) through 1(p) for hospital providers, and on pages 2(h) through 2(t) for freestanding clinic providers, are authorized by State law, agreed to by both the New York State Commissioner of Health and the applicable facility, and do not result in aggregate payments lower than the payments calculated under the existing approved methodology for such facility.

TN #08-36 \_\_\_\_\_

Approval Date MAY 26 2008

Supersedes TN #06-11 \_\_\_\_\_

Effective Date DEC 01 2008

New York  
2(c)(iv)(b)

**OFFICIAL**

**Attachment 4.19-B  
(07/08)**

For providers choosing to be reimbursed under the Ambulatory Patient Group (APG) methodology, the Department will reconcile amounts actually paid in a calendar year through APG; to that which would have been paid through the PPS methodology. Adjustments will be made based upon this comparison to ensure that providers are not paid less than they would have under PPS.

TN #08-36 \_\_\_\_\_

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Effective Date DEC 01 2008

**OFFICIAL**

New York  
2(c)(v)

Attachment 4.19-B  
(04/08)

### Hospital Outpatient Payment Adjustment

Effective for the period January 1, 2002 through March 31, 2002, and state fiscal years beginning April 1, 2002, for services provided on or after January 1, 2002, the Department of Health will increase the operating cost component of rates of payment for hospital outpatient and emergency room services for public general hospitals other than those operated by the State of New York or the State University of New York, which experienced free patient visits in excess of 20 percent of their total self-pay and free patient visits based on data reported on Exhibit 33 of their 1999 Institutional Cost Report and which experienced uninsured outpatient losses in excess of 75% of their total inpatient and outpatient uninsured losses based on data reported on Exhibit 47 of their 1999 Institutional Cost Report, and are located in a city with a population of over one million. The amount to be paid will be up to thirty seven million dollars for the period beginning January 1, 2002 and ending March 31, 2002 and one hundred fifty-one million dollars annually for state fiscal years beginning April 1, 2002 and ending March 31, 2005. For state fiscal year beginning April 1, 2005 and ending March 31, 2006, the amount to be paid will be \$222,781,000. For state fiscal year beginning April 1, 2006 and ending March 31, 2007, the amount to be paid will be \$229,953,000. For state fiscal year beginning April 1, 2007 and ending March 31, 2008, the amount to be paid will be \$224,050,000. For state fiscal year beginning April 1, 2007 and ending March 31, 2008, the amount to be paid will be \$211,865,219. For state fiscal year beginning April 1, 2008 and ending March 31, 2009, the amount to be paid will be \$183,365,199. Medical assistance payments will be made for outpatient services for patients eligible for federal financial participation under Title XIX of the Federal Social Security Act based on each such hospital's proportionate share of the sum of all outpatient visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

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**OFFICIAL**

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2(c)(vi)

Attachment 4.19-B  
(04/05)

**Hospital Outpatient Payment Adjustment**

Effective for the period January 1, 2002 through March 31, 2002, and state fiscal years beginning April 1, 2002 [and ending March 31, 2005], for services provided on or after January 1, 2002, the Department of Health will increase the operating cost component of rates of payment for hospital outpatient and emergency room services for government general hospitals other than those operated by the State of New York or the State University of New York, which experienced free patient visits in excess of 20 percent of their total self-pay and free patient visits based on data reported on Exhibit 33 of their 1999 Institutional Cost Report and which experienced uninsured outpatient losses in excess of 75% of their total inpatient and outpatient uninsured losses based on data reported on Exhibit 47 of their 1999 Institutional Cost Report, and are located in a city with a population of over one million. The amount to be paid will be up to thirty four million dollars for the period beginning January 1, 2002 [through] and ending March 31, 2002 and [up to] one hundred thirty six million dollars annually for state fiscal years beginning April 1, 2002 and ending March 31, 2005. Medical assistance payments will be made for outpatient services for patients eligible for federal financial participation under Title XIX of the Federal Social Security Act based on each such hospital's proportionate share of the sum of all outpatient visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

Effective for the period January 1, 2002 through March 31, 2002, and state fiscal years beginning April 1, 2002 and ending March 31, 2005, for services provided on or after January 1, 2002, the Department of Health will increase the operating cost component of rates of payment for hospital outpatient and emergency room services for government general hospitals operated by a county of the state of New York, which shall not include a city with a population over one million, and including those government hospitals located in the counties of Westchester and Nassau. The amount to be paid will be up to an aggregate of fifteen million dollars for the period January 1, 2002 through March 31, 2002, and up to an aggregate of sixty million dollars annually for state fiscal years beginning April 1, 2002 and ending March 31, 2005. Medical assistance payments for outpatient services will be made for patients eligible for federal financial participation under Title XIX of the Federal Social Security Act. The allocation of aggregate payments among qualifying hospitals shall be based on each such hospital's proportionate share of the sum of all estimated differences in outpatient medical assistance payments and one hundred fifty percent of a reasonable estimate of the amount that would have been paid for such services under Medicare payment principles for the respective periods. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

TN #05-26

Approval Date MAR 18 2010

Supersedes TN #03-31

Effective Date APR 01 2005

**Workforce Recruitment And Retention**

Effective for dates of service beginning on April 1, 2002 and ending on March 31, 2008, medical assistance rates of payment shall be adjusted for comprehensive freestanding diagnostic and treatment centers that qualify for distributions under the state's comprehensive diagnostic and treatment centers indigent care program or indicate on the cost reports submitted to the state that they receive funding under section three hundred thirty-three of the Federal Public Health Services Act for health care for the homeless, freestanding clinics that provide services to clients with developmental disabilities as their principal mission, licensed facilities authorized to provide dental services and sponsored by a university or dental school, licensed freestanding family planning clinics, and freestanding diagnostic and treatment centers operating an approved program under the prenatal care assistance program to include costs associated with the recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. For the period April 1, 2002 through December 31, 2002, the aggregate amount of thirteen million dollars will be available for this purpose. The aggregate amount of thirteen million dollars will also be available each year for the periods January 1, 2003 through December 31, 2006. For the period January 1, 2007 through June 30, 2007 the aggregate amount of six million five hundred thousand dollars will be available for this purpose. For the period July 1, 2007 through March 31, 2008, nine million seven hundred fifty thousand dollars will be available. For the period April 1, 2008 through March 31, 2009, thirteen million dollars will be available. For the period April 1, 2009 through March 31, 2010, thirteen million dollars will be available. For the period April 1, 2010 through March 31, 2011, thirteen million dollars will be available. Payments will be made as adjustments to the rates of payment allocated proportionately based upon each diagnostic and treatment center's total annual gross salary and fringe benefit costs as reported in their 1999 cost report submitted to the Department of Health prior to November 21, 2001. These amounts shall be included as a reimbursable cost add-on to medical assistance fee-for-service rates of payment established pursuant to this section, based on Medicaid utilization data in each facility's annual cost report submitted two years prior to the rate year or projected Medicaid utilization data for those facilities that have not submitted an annual cost report for the period two years prior to the rate year. Such amounts shall not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year. For the periods on and after July 1, 2007, payments will be made as adjustments to the rates of payment and the available funding allocated proportionately based upon each diagnostic and treatment center's total reported Medicaid visits as reported in their 2004 cost report submitted to the Department of Health prior to January 31, 2007, to the total of such Medicaid visits for all diagnostic and treatment centers.

The Commissioner of Health shall increase medical assistance rates of payment [for eligible diagnostic and treatment centers] by three percent for services provided on and after December first, two thousand two for purposes of improving recruitment and retention of non-supervisory

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**Attachment 4.19-B  
(04/08)**

workers or any worker with direct patient care responsibility for]. Eligible diagnostic and treatment center shall mean a) voluntary, not-for-profit diagnostic and treatment centers that received medical assistance rates of payment reflecting assignment to (1) limited primary care or (2) drug free peer groups and that provides primary health care services to a patient population primarily comprised of substance abuse patients and that [is] are ineligible for an adjustment to medical assistance rates of payment under the first paragraph of this section of the plan.

Diagnostic and treatment centers which have their rates adjusted for this purpose shall use such funds solely for the purposes of recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. The commissioner is authorized to audit each such diagnostic and treatment center to ensure compliance with this purpose and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility.

The Commissioner shall increase medical assistance rates of payment by three percent for services provided on and after December first, two thousand two by freestanding methadone maintenance service and program providers; subject to provisions of the following paragraph. Freestanding methadone maintenance services and program providers which are eligible for rate adjustments pursuant to this paragraph and which are also eligible for rate adjustments pursuant to the first paragraph of this section of the plan shall, on or before July first, two thousand two, submit, amendments to their 1999 AHCF-1 cost report segregating wages and fringe benefit costs associated with methadone maintenance services, for the purpose of excluding such wages and fringe benefits from awards determined on and after January 1, 2003, pursuant to the first paragraph of this section of the plan titled Workforce Recruitment And Retention.

Freestanding methadone maintenance service and program providers which have their rates adjusted in accordance with the above shall use such funds solely for the purpose of recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. The Commissioner is authorized to audit each freestanding methadone maintenance services and program provider to ensure compliance with this purpose and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility.

**TN #08-30** \_\_\_\_\_

**Approval Date** \_\_\_\_\_

**JUL 26 2010**

**Supersedes TN #07-33** \_\_\_\_\_

**Effective Date** \_\_\_\_\_

**APR 01 2008**

TYPE OF SERVICE

Products of Ambulatory Care (PACS) for Hospital-Based Clinics and Freestanding Diagnostic and Treatment Centers [(August 1, 1990 through July 31, 1991)]

METHOD OF REIMBURSEMENT

The [products] Products of Ambulatory Care (PACs) Reimbursement Program uses a prospective reimbursement method associated with resource use patterns to insure that ambulatory services are economically and efficiently provided, and to provide incentives to foster continuity of care and treatment for patients. All participating providers, both hospital based clinics and freestanding diagnostic and treatment centers, are placed under a uniform, prospective, modified priced based system. The methodology is based upon the assignment of an ambulatory care visit into one of 24 mutually exclusive PAC groups. Under the reimbursement method, facility specific payment rates are established for each of the 24 PAC groups. Each rate in the payment model is comprised of two components -- a case mix related price component and a facility component. The price component includes values for labor, ancillaries and medical supplies for which values are based upon current market prices. The facility specific cost components include pharmacy, facility, teaching and capital costs, and are based on a providers reported historical costs subject to ceiling limitations where applicable. Pharmacy and routine capital costs are fully reimbursed, although they are subject to desk audit adjustments.

The PAC payment method is an alternative to the prospective average cost per visit reimbursement method used for non - participating hospitals and diagnostic and treatment centers. There are unique

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 Supersedes TN 90-38 Effective Date AUG 1 1991

TYPE OF SERVICE

Products of Ambulatory Care (PACS) for Hospital-Based Clinics and Freestanding Diagnostic and Treatment Centers [(August 1, 1990 through July 31, 1991)]

METHOD OF REIMBURSEMENT

features present in the PACS reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the submission of patient encounter data by providers to the New York State Department of Health, financial responsibility by providers for selected laboratory and other ancillary procedures and Medicaid Revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.

Hospital-based clinics and freestanding diagnostic and treatment centers seeking PACS reimbursement are required to enter into a Memorandum of Participation with the New York State Department of Health.

TN 91-63Approved Date OCT 31 1991Supersedes TN 90-38Effective Date AUG 1 1991

Reserved

[Type of Service      Method of Reimbursement

Medically Supervised, Ambulatory Substance Abuse Treatment Services (Facilities certified under Article 23 of Mental Hygiene Law)

Prospective, provider-specific, all inclusive rates calculated by the State Division of Substance Abuse Services (DSAS):

- 1) For providers which have at least twelve months of previous history of operation as a medically supervised, ambulatory substance abuse treatment program, the rate is based on historical costs per visit held to Ceiling limitations mutually agreed upon by DSAS and DSS and trended forward to the current rate period to adjust for inflation or deflation; or,
- 2) providers which have less than twelve months history of operation as a medically supervised ambulatory substance abuse treatment program, a temporary prospective rate is calculated first taking the weighted average of all the rates calculated in (1) above, and then taking a percentage of that amount to arrive at the temporary prospective rates for all providers with less than twelve months history. A final rate will be calculated, based on actual costs from the first twelve months of operation under the temporary prospective rate, according to (1) above.

All rates are in effect for a two year period. Rates are subject to the approval of SDSS and Division of Budget. Rates are promulgated by SDSS.]

TN 02-16

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Attachment 4.19-B  
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(07/03)

**Comprehensive Diagnostic And Treatment Center Indigent Care Program**

For periods on and after July 1, 2003, the Commissioner of Health shall adjust medical assistance rates of payment to assist in meeting losses resulting from uncompensated care.

Eligible diagnostic and treatment centers shall mean voluntary non-profit and publicly sponsored diagnostic and treatment centers providing a comprehensive range of primary health care services which can demonstrate losses from disproportionate share of uncompensated care during a base period two years prior to the grant period.

Uncompensated care need means losses from reported self-pay and free visits multiplied by the facility's medical assistance payment rate for the applicable distribution year, offset by payments received from such patients during the reporting period.

A diagnostic and treatment center qualifying for a distribution or a rate adjustment shall provide assurances satisfactory to the Commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third-party insurance payors, governmental payors and self-paying patients.

To be eligible for an allocation of funds or a rate adjustment, a diagnostic and treatment center must provide a comprehensive range of primary health care services and must demonstrate that a minimum of five percent of total clinic visits reported during the applicable base year period were to uninsured individuals. The Commissioner may retrospectively reduce the allocations of funds or the rate adjustments to a diagnostic and treatment center if it is determined that provider management actions or decisions have caused a significant reduction for the applicable period in the delivery of comprehensive primary health care services to uncompensated care residents of the community.

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For periods on and after July 1, 2003, funds shall be made available for adjustments to rates of payments for the following categories of eligible comprehensive voluntary diagnostic and treatment centers (D&TCs) for the following periods in the following aggregate amounts:

**Voluntary Non-Profit D&TCs**

- A. For the period July 1, 2003 through December 31, 2003, up to seven million five hundred thousand dollars;
- B. For the period January 1, 2004 through December 31, 2004, up to fifteen million dollars;
- C. For the period January 1, 2005 through June 30, 2005, up to seven million five hundred thousand dollars.

**Public D&TCs, other than those operated by the New York City Health and Hospitals Corp.**

- A. For the period July 1, 2003 through December 31, 2003, up to nine million dollars;
- B. For the period January 1, 2004 through December 31, 2004, up to eighteen million dollars;
- C. For the period January 1, 2005 through June 30, 2005, up to nine million dollars.

**Public D&TCs Operated by the New York City Health and Hospitals Corporation**

- A. For the period July 1, 2003 through December 31, 2003, up to six million dollars;
- B. For the period January 1, 2004 through December 31, 2004, up to twelve million dollars;
- C. For the period January 1, 2005 through June 30, 2005, up to six million dollars.

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## Methodology

A nominal payment amount for the financing of losses associated with the delivery of uncompensated care will be established for each eligible diagnostic and treatment center in each of the following categories: voluntary non-profit Diagnostic and Treatment Centers (D&TCs), public D&TCs other than those operated by the New York City Health And Hospitals Corporation, and public D&TCs operated by the New York City Health And Hospitals Corporation. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of uncompensated care for percentage increases in the relationship between base year period eligible uninsured care clinic visits and base year period total clinic visits according to the following scale:

<u>Percent of eligible bad debt and charity care clinic visits to total visits</u>	<u>Percent of nominal financial loss coverage</u>
<u>up to 15%</u>	<u>50%</u>
<u>15-30%</u>	<u>75%</u>
<u>over 30%</u>	<u>100%</u>

The uncompensated care rate adjustments for each eligible diagnostic and treatment center shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for diagnostic and treatment centers within the applicable category to the total statewide nominal payment amounts for all eligible diagnostic and treatment centers within the applicable category applied to the nominal payment amount for each such diagnostic and treatment center.

Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible diagnostic and treatment centers and shall not be subject to subsequent adjustment or reconciliation.

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**Non-Hospital Based Freestanding or Local Health Department Operated General Medical Clinics**

Non-hospital based freestanding or local health department operated general clinics sponsored by municipalities that received state aid for the 1989-90 state fiscal year in support of non-hospital based free-standing or local health department operated general medical clinics shall receive an uncompensated care rate adjustment for the period July 1, 2003 through December 31, 2003, of not less than one-half the amount received in the 1989-90 state fiscal year for general medical clinics.

For the period January 1, 2004 through December 31, 2004, each such eligible general clinic shall receive an uncompensated care rate adjustment of not less than twice the amount calculated pursuant to the previous paragraph.

For the period January 1, 2005 through June 30, 2005, each such eligible general clinic shall receive an uncompensated care rate adjustment of not less than the amount calculated pursuant to the first paragraph.

Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible general clinics and shall not be subject to subsequent adjustment or reconciliation.

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## Diagnostic And Treatment Centers With Less Than Two Years Operating Experience

For periods on and after July 1, 2003, funds shall be made available for adjustments to rates of payment for eligible diagnostic and treatment centers with less than two years of operating experience, and diagnostic and treatment centers which have received certificate of need approval on applications which indicate a significant increase in uninsured visits, for the following periods and in the following aggregate amounts:

- For the period July 1, 2003 through December 31, 2003, up to one million five hundred thousand dollars;
- For the period January 1, 2004 through December 31, 2004, up to three million dollars;
- For the period January 1, 2005 through June 30, 2005, up to one million five hundred thousand dollars.

To be eligible for a rate adjustment, a diagnostic and treatment center shall be a voluntary non-profit or publicly sponsored diagnostic and treatment center providing a comprehensive range of primary health care services and be eligible to receive a Medicaid budgeted rate prior to April first of the applicable rate adjustment period after which time, the Department shall issue rate adjustments pursuant to the information provided in this plan for such periods. Rate adjustments made pursuant to this section shall be allocated based upon each eligible facility's proportional share of costs for services rendered to uninsured patients which have otherwise not been used for establishing distributions to the total of all qualifying facilities. For the purposes of this section, costs shall be measured by multiplying each facility's Medicaid budgeted rate by the estimated number of visits reported for services anticipated to be rendered to uninsured patients meeting the aforementioned criteria, less any anticipated patient service revenues received from such uninsured patients, during the applicable rate adjustment period.

Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible diagnostic and treatment centers and shall not be subject to subsequent adjustment or reconciliation.

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**Ambulatory Patient Group System**

For dates of service beginning September 1, 2009 through June 30, 2012, for freestanding Diagnostic and Treatment Center (D&TC) and ambulatory surgery center services, the operating component of rates shall be reimbursed using a methodology that is prospective and associated with resource utilization to ensure that ambulatory services are economically and efficiently provided. The methodology is based upon the Ambulatory Patient Group (APG) classification and reimbursement system. This methodology incorporates payments for the separate covered Medicaid benefits in accordance with the payment methods for these services. Reimbursement for the capital component of these rates shall be made as an add-on to the operating component as described on Page 2(m) of this section.

The Ambulatory Patient Group patient classification system is designed to explain the amount and type of resources used in an ambulatory visit by grouping patients with similar clinical characteristics and similar resource use into a specific APG. Each procedure code associated with a patient visit is assigned to an APG using the grouping logic developed by 3M Health Information Systems (3M). When evaluation and management codes are coded, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

**The following is a list of definitions relating to the Ambulatory Patient Group reimbursement system.**

**Allowed APG Weight** shall mean the relative resource utilization for a given APG after adjustment for bundling, packaging, and discounting;

**Ambulatory Patient Group (APG)** shall mean a group of outpatient procedures, encounters or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of ICD-9-CM diagnosis and HCPCS procedure codes, as defined below. APG are defined under 3M's grouping logic outlined in the APG Definitions Manual version 3.1 dated March 6, 2008 and as subsequently amended by 3M;

**APG Relative Weight** shall mean a numeric value that reflects the relative expected average resource utilization (cost) for each APG as compared to the expected average resource utilization for all other APGs.

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**Ancillary Services** shall mean laboratory and radiology tests and procedures ordered to assist in patient diagnosis and/or treatment. A list of ancillary services is available on the NYSDOH website at: [http://www.nyhealth.gov/health\\_care/medicaid/rates/apg/index.htm](http://www.nyhealth.gov/health_care/medicaid/rates/apg/index.htm).

**APG Software** shall mean the New York State-specific version of the APG computer software developed and published by 3M Health Information Systems (3M) to process HCPCS/CPT-4 and ICD-9-CM code information in order to assign patient visits, at the procedure code level, to the appropriate APGs and apply appropriate bundling, packaging, and discounting logic to in turn calculate the final APG weight and allowed reimbursement for a patient visit. Each time the software is updated, 3M will automatically send updated software to all license holders. Providers and other interested parties that do not purchase the grouper software, can perform the computations by accessing the APG definitions manual, which is available on the 3M website. The appropriate link can also be found on the NYSDOH website.

**Base Rate** shall mean the dollar value that shall be multiplied by the allowed APG weight for a given APG, or by the final APG weight for each APG on a claim to determine the total allowable Medicaid operating payment for a visit.

**Case Mix Index** is the actual or estimated average final APG weight for a defined group of APG visits.

**Coding Improvement Factor** is a numeric value used to adjust for more complete and accurate coding for visits upon implementation of the APG reimbursement system. The current coding improvement factors are 10.20 for freestanding clinics, 3.59 for ambulatory surgery centers, 2.14 for renal centers, and 4.57 for dental schools.

**Consolidation/Bundling** shall mean the process for determining if a single payment amount is appropriate in those circumstances when a patient receives multiple APG procedures during a single patient visit. In some cases, a procedure will be considered part of a more complicated procedure. In this case the payment for the less complicated procedure will be included in the payment for the more complicated procedure and the claim line for the less complicated procedure will show zero payment for that procedure. Consolidation logic is defined in the 3M Health Information Systems' APG Definitions Manual version 3.1 dated March 6, 2008, and as subsequently amended by 3M.

**Current Procedural Terminology-fourth edition (CPT-4)** is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. It is a subset of the Healthcare Common Procedure Coding System (HCPCS). The CPT-4 is maintained by the American Medical Association and HCPCS are maintained by the Centers for Medicare and Medicaid Services. Both coding systems are updated annually.

**Discounting** shall mean the reduction in APG payment that results when related procedures or ancillary services are performed during a single patient visit. Discounting is always at the rate of 50%.

**Final APG Weight** shall mean the allowed APG weight for a given visit as calculated by the APG software using the logic in the APG definitions manual, including all adjustments applicable bundling, packaging, and discounting.

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"HCPCS Codes" are from the Healthcare Common Procedure Coding System, a numeric coding system maintained by the Centers for Medicare and Medicaid Services (CMS) and used to identify services and procedures for purposes of billing public or private health insurance programs. CPT (Common Procedure Terminology) codes are a subset of the HCPCS coding system.

International Classification of Diseases, 9th Revision-Clinical Modification (ICD-9-CM) is a comprehensive coding system maintained by the federal Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services. It is maintained for the purpose of providing a standardized, universal coding system to identify and describe patient diagnosis, symptoms, complaints, condition and/or causes of injury or illness. It is updated annually.

Packaging shall mean those circumstances in which payment for routine ancillary services or drugs shall be deemed as included in the applicable APG payment for a related significant procedure or medical visit. There is no packaging logic that resides outside the software.

"Peer Group" shall mean a group of providers or services that share a common APG base rate. Peer groups may be established based on a geographic region, service type, or categories of patients. There are ten DTC peer groups for initial APG implementation: General Clinic upstate; General Clinic downstate; Academic Dental upstate; Academic Dental downstate; Ambulatory Surgery upstate; Ambulatory Surgery downstate; Renal upstate; Renal downstate; Mental Retardation, Developmental Disability, Traumatic Brain Injured upstate; and Mental Retardation, Developmental Disability, Traumatic Brain Injured downstate.

"Region" shall mean the counties constituting a peer group that has been defined, at least in part, on a regional basis. The downstate region shall consist of the five counties comprising New York City, as well as the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The upstate region shall consist of all other counties in New York State.

"Visit" shall mean a unit of service consisting of all the APG services performed for a patient on a single date of service and related ancillary services.

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**Reimbursement Methodology**

- I. The initial calculation of the APG relative weights were developed using line level charges from 2005 New York Medicaid hospital claims converted to cost using the ratio of cost to charges methodology. The line level costs were brought up to the APG level to determine the average cost of each APG.
- a. The APG relative weights shall be updated at least annually based on hospital claims data. These APG and weights are set as of September 1, 2009, and are effective for specified services on and after that date. The APG's and their relative weights are published on the NYS Department of Health website at: [http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/docs/proposed\\_regulations.pdf](http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/proposed_regulations.pdf).
- b. The APG relative weights shall be re-weighted prospectively. The initial re-weighting will be based on Medicaid claims data for hospitals from the December 1, 2008 through September 30, 2009 period. Subsequent re-weightings will be based on Medicaid hospital claims data from the most recent twelve month period and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.
- c. The Department shall correct material errors of any given APG relative weight. Such corrections shall make use of benchmarking data consisting of payment information from other payers (including Medicare) reimbursing comparable services. Corrections to material errors in individual APG relative weights shall be made on a prospective basis.
- II. The case mix index is an expression of the average paid APG weight for a given peer group after consolidation, packaging, and discounting. Case mix indices shall be calculated by running applicable freestanding D&TC and ambulatory surgery center claims data through the latest version of the APG software to determine the average final APG weight of the visits. Outlier claims or claim lines may be excluded from this calculation to assure overall accuracy of the final case mix index. The initial recalculation of case mix indices will be based on freestanding D&TC and ambulatory surgery center Medicaid data from the January 1, 2009 through November 30, 2009 period. Subsequent recalculations will be based on freestanding D&TC and ambulatory surgery center Medicaid claims data from the most recent twelve month period.

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III. The APG base rates shall be updated at least annually. The initial update will be based on claims data from the September 1, 2009 through November 30, 2009 period, and subsequent updates will be based on Medicaid claims data from the most recent twelve month period, and will be based on complete and accurate billing data. APG base rates shall be rebased each time the APG relative weights are reweighted.

a. If it is determined by the Department that an APG base rate is materially incorrect, the Department shall correct that base rate prospectively so as to align aggregate reimbursement with total available funding. APG payments shall also reflect an investment of \$13.54 million for dates of service from September 1, 2009 through March 31, 2010, and \$12.5 million for each annual period thereafter. The case mix index shall be calculated using 2005 claims data.

IV. For the period September 1, 2009 to November 30, 2009, the APG base rates shall be calculated using the total operating reimbursement for services and related ancillaries and the associated number of visits for services moving to APG reimbursement for the period January 1, 2007 to December 31, 2007. APG payments shall also reflect an investment of \$13.54 million for dates of service from September 1, 2009 through March 31, 2010, and \$12.5 million for each annual period thereafter. The case mix index shall be calculated using 2005 claims data.

a. For all rate periods subsequent to November 30, 2009, estimated total operating reimbursement for services and related ancillaries and the estimated number of visits shall be calculated based on historical claims data. The initial reestimation will be based on claims data from the September 1, 2009 through November 30, 2009, and subsequent modifications will be based on Medicaid claims data from the most recent twelve month period, and will be based on complete and accurate data.

b. The estimated case mix index shall be calculated using the appropriate version of the 3M APG software based on claims data. This initial estimate will be adjusted based on Medicaid freestanding D&TC and ambulatory surgery center claims data from the September 1, 2009 through November 30, 2009 period, and subsequent modifications will be based on Medicaid freestanding D&TC and ambulatory surgery center claims data from the most recent twelve month period, and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

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V. Rates for new D&TC clinics during the transition period

- a. D&TC clinics which commence operation after December 31, 2007, and prior to January 1, 2012, and for which rates computed pursuant to the Public Health Law are not available shall have the capital cost component of their rates based on a budget as submitted by the facility and as approved by the Department and shall have the operating component of their rates computed in accordance with the following:
- b. For the period September 1, 2009 through December 31, 2009, 75% of such rates shall reflect the historical 2007 regional average peer group payment per visit as calculated by the Department, and 25% of such rates shall reflect APG rates as described beginning on Page 2(k) of this plan amendment;
- c. For the period January 1, 2010 through December 31, 2010, 50% of such rates shall reflect the historical 2007 regional average peer group payment per visit as calculated by the Department, and 50% of such rates shall reflect APG rates as described beginning on Page 2(k) of this plan amendment;
- d. For the period January 1, 2011 through December 31, 2011, 25% of such rates shall reflect the historical 2007 regional average peer group payment per visit as calculated by the Department, and 75% of such rates shall reflect APG rates as described on Page 2(k) of this plan amendment;
- e. For periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as described on Page 2(k) of this plan amendment;
- f. For the purposes of this subdivision, the historical 2007 regional average peer group payment per visit shall mean the result of dividing the total facility specific Medicaid reimbursement paid for D&TC clinic claims for each peer group, as defined on Page 2(i) of this plan amendment paid in the 2007 calendar year in the applicable upstate or downstate region for all rate codes reflected in the APG rate-setting methodology, divided by the total visits on claims paid under such rate codes.

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- VI. Rates for new freestanding ambulatory surgery centers during the transition period
- a. Freestanding ambulatory surgery centers which commence operation after December 31, 2007, and prior to January 1, 2012, and for which rates computed pursuant to Public Health Law §2807(2) are not available, shall have the capital cost component of their rates computed in accordance with the methodology described in item IV on page 2(o) of this plan amendment and shall have the operating cost component of their rates computed in accordance with the following:
  - b. For the period September 1 2009 through December 31, 2009, 75% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 25% of such rates as described beginning on Page 2(k) of this plan amendment;
  - c. For the period January 1, 2010 through December 31, 2010, 50% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 50% of such rates shall reflect APG rates as described beginning on Page 2(k) of this plan amendment;
  - d. For the period January 1, 2011 through December 31, 2011, 25% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 75% of such rates shall reflect APG rates as described on Page 2(k) of this plan amendment;
  - e. For periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as described on Page 2(k) of this plan amendment; and
  - f. For the purposes of this subdivision, the historical 2007 regional average peer group payment per visit shall mean the result of dividing the total facility specific Medicaid reimbursement paid for freestanding ambulatory surgery centers services claims paid in the 2007 calendar year in the applicable upstate or downstate region for all rate codes reflected in the APG rate-setting methodology, divided by the total visits on claims paid under such rate codes.

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**APG Rate Computation**

The following is a description of the methodology to be utilized in calculating rates of payment under the Ambulatory Patient Group classification and reimbursement system.

- I. Claims containing ICD-9 diagnostic and CPT-4 procedure codes are submitted to the Department on appropriate forms or in the accepted electronic format.
- II. Claims are reviewed electronically to assign each valid procedure code to the appropriate APG using the APG software logic. Invalid codes will be assigned to an error APG and not given further consideration in the payment process.
- III. Each valid APG on the claim is assigned a relative weight. At this time the software logic also determines an allowed weight based upon whether each APG on the claim is to be paid in full, packaged, consolidated, or discounted.
- IV. The allowed weights for each valid APG on the claim are then summed to arrive at the final weight for this claim. This final weight is multiplied by an operating base rate that is specific to the peer group to which the claim has been assigned resulting in the APG operating cost reimbursement amount for this claim. For freestanding clinic services, capital will continue to be paid as an add-on using the existing, previously approved methodology. The capital cost component for ambulatory surgery services shall be the result of dividing the total amount of capital cost reimbursement paid to such facilities pursuant to the current Products of Ambulatory Surgery (PAS) system for the 2007 calendar year for the Upstate Region and for the Downstate Region and then dividing each such regional total amount by the total number of claims paid through the PAS system within each such region for the 2007 calendar year.
- V. A separate base rate calculation shall be calculated for each peer group established by the Department. All Medicaid reimbursement paid to facilities for services moving to the APG reimbursement system (e.g., freestanding clinic and ambulatory surgery center services); during the 2007 calendar year and associated ancillary payments will be added to an investment of \$13.54 million for dates of service from September 1, 2009 through March 31, 2010, and \$12.5 million for each annual period thereafter to form the numerator. The peer group specific case mix index multiplied by the coding improvement factor and the 2007 base year visits will form the denominator resulting in a base rate for that peer group.

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The following is an example of a sample APG base rate calculation:

a. <u>2007 Peer Group Reimbursement</u>	<u>\$51,000,000</u>
b. <u>Additional Investment</u>	<u>\$25,000,000</u>
c. <u>Case Mix Index</u>	<u>8.1610</u>
d. <u>Coding Improvement Factor</u>	<u>1.05</u>
e. <u>2007 Base Year Visits</u>	<u>50,000</u>

$$(\$51,000,000 + \$25,000,000) / (8.1610 \times 1.05 \times 50,000) = \$177.38 \text{ (Base Rate)}$$

VI. During the transition period, reimbursement for freestanding clinic and ambulatory surgery center services shall consist of a blend of each facility's average 2007 Medicaid rate and the APG calculation for that visit. The average 2007 Medicaid rate for purposes of blending is computed by dividing the amount paid in calendar year 2007 for all rate codes reflected in the APG rate setting methodology, by the total visits paid through those codes for the same time period. In the initial phase (ending December 31, 2009), 25% of the operating payment for each visit will be based upon the APG reimbursement methodology and 75% will be based upon the provider specific average operating payment for calendar year 2007. During 2010, the blend will be 50/50. During 2011, the blend will be 75/25. Payments will be based upon 100% of the APG operating component beginning on January 1, 2012. Per the enabling statute, as new services the Education APGs and the Extended Hours APGs are not subject to the blend requirement.

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The following shall be excluded from the APG reimbursement system:

- Drugs and other pharmaceutical products and implantable family planning devices for which separate and distinct outpatient billing and payment were authorized by the Department as of December 31, 2007, and as set forth by the Department in written billing instructions issued to providers.
- HIV counseling and testing visits, HIV counseling (no testing), post-test HIV counseling visits (positive results), day health care service (HIV).
- TB/directly observed therapy - downstate levels 1 and 2, TB/directly observed therapy.
- Upstate levels 1 and 2, AIDS clinic therapeutic visits in general hospital outpatient clinics.
- Child rehabilitation services provided under rate code 2887 in general hospital outpatient clinics.
- Medicaid obstetrical and maternity services (MOMS) provided under rate code 1604.
- Visits solely for the purpose of receiving ordered ambulatory services.
- Visits solely for the purpose of receiving pharmacy services.
- Visits solely for the purpose of receiving education or training services, except with regard to services authorized pursuant to clause (A) of subparagraph (ii) of paragraph (f) of subdivision 2-a of §2807 of the Public Health Law.
- Visits solely for the purpose of receiving services from licensed social workers, except with regard to psychotherapy services provided by Federally Qualified Health Centers or Rural Health Centers choosing to participate in the APG system, or as authorized pursuant to clauses (C) and (D) of subparagraph (ii) of paragraph (f) of subdivision 2-a of §2807 of the Public Health Law.
- Visits solely for the purpose of receiving group services, except with regard to clinical group psychotherapy services provided by Federally Qualified Health Centers or Rural Health Centers choosing to participate in the APG system and provided, however, that reimbursement for such group services shall be determined in accordance with state regulation.
- Offsite services, defined as medical services provided by a facility's outpatient staff at locations other than those operated by and under the facility's licensure under Article 28 of the Public Health Law, or visits related to the provision of such offsite services, except with regard to offsite services provided by Federally Qualified Health Centers or Rural Health Centers.

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The following APGs shall not be eligible for reimbursement through the APG system:

065    RESPIRATORY THERAPY  
066    PULMONARY REHABILITATION  
094    CARDIAC REHABILITATION  
117    HOME INFUSION  
118    NUTRITION THERAPY  
190    ARTIFICIAL FERTILIZATION  
311    FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE  
312    FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS  
313    HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE  
314    HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS  
319    ACTIVITY THERAPY  
320    CASE MANAGEMENT - MENTAL HEALTH OR SUBSTANCE ABUSE  
371    ORTHODONTICS  
427    BIOFEEDBACK AND OTHER TRAINING  
430    CLASS I CHEMOTHERAPY DRUGS  
431    CLASS II CHEMOTHERAPY DRUGS  
432    CLASS III CHEMOTHERAPY DRUGS  
433    CLASS IV CHEMOTHERAPY DRUGS  
434    CLASS V CHEMOTHERAPY DRUGS  
450    OBSERVATION  
452    DIABETES SUPPLIES  
453    MOTORIZED WHEELCHAIR  
454    TPN FORMULAE  
456    MOTORIZED WHEELCHAIR ACCESSORIES  
492    DIRECT ADMISSION FOR OBSERVATION INDICATOR  
500    DIRECT ADMISSION FOR OBSERVATION - OBSTETRICAL  
501    DIRECT ADMISSION FOR OBSERVATION - OTHER DIAGNOSES  
999    UNASSIGNED

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**OFFICIAL**

New York  
2(s)

Attachment 4.19-B  
(1/09)

The following APGs shall not be eligible for reimbursement when they are presented as the only APG or APGs applicable to a patient visit or when the only other APGs presented with them are one or more of the APGs listed in the list of APGs not eligible for reimbursement:

- 280 VASCULAR RADIOLOGY EXCEPT VENOGRAPHY OF EXTREMITY
- 284 MYELOGRAPHY
- 285 MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST
- 286 MAMMOGRAPHY
- 287 DIGESTIVE RADIOLOGY
- 288 DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL AND VASCULAR OF LOWER EXTREMITIES
- 289 VASCULAR DIAGNOSTIC ULTRASOUND OF LOWER EXTREMITIES
- 290 PET SCANS
- 291 BONE DENSITOMETRY
- 298 CAT SCAN - BACK
- 299 CAT SCAN - BRAIN
- 300 CAT SCAN - ABDOMEN
- 301 CAT SCAN - OTHER
- 302 ANGIOGRAPHY, OTHER
- 303 ANGIOGRAPHY, CEREBRAL
- 330 LEVEL I DIAGNOSTIC NUCLEAR MEDICINE
- 331 LEVEL II DIAGNOSTIC NUCLEAR MEDICINE
- 332 LEVEL III DIAGNOSTIC NUCLEAR MEDICINE
- 380 ANESTHESIA
- 390 LEVEL I PATHOLOGY
- 391 LEVEL II PATHOLOGY
- 392 PAP SMEARS
- 393 BLOOD AND TISSUE TYPING
- 394 LEVEL I IMMUNOLOGY TESTS
- 395 LEVEL II IMMUNOLOGY TESTS
- 396 LEVEL I MICROBIOLOGY TESTS
- 397 LEVEL II MICROBIOLOGY TESTS
- 398 LEVEL I ENDOCRINOLOGY TESTS
- 399 LEVEL II ENDOCRINOLOGY TESTS
- 400 LEVEL I CHEMISTRY TESTS
- 401 LEVEL II CHEMISTRY TESTS
- 402 BASIC CHEMISTRY TESTS
- 403 ORGAN OR DISEASE ORIENTED PANELS
- 404 TOXICOLOGY TESTS
- 405 THERAPEUTIC DRUG MONITORING

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406 LEVEL I CLOTTING TESTS  
407 LEVEL II CLOTTING TESTS  
408 LEVEL I HEMATOLOGY TESTS  
409 LEVEL II HEMATOLOGY TESTS  
410 URINALYSIS  
411 BLOOD AND URINE DIPSTICK TESTS  
413 CARDIOGRAM  
414 LEVEL I IMMUNIZATION AND ALLERGY IMMUNOTHERAPY  
415 LEVEL II IMMUNIZATION  
416 LEVEL III IMMUNIZATION  
435 CLASS I PHARMACOTHERAPY  
436 CLASS II PHARMACOTHERAPY  
437 CLASS III PHARMACOTHERAPY  
438 CLASS IV PHARMACOTHERAPY  
439 CLASS V PHARMACOTHERAPY  
451 SMOKING CESSATION TREATMENT  
455 IMPLANTED TISSUE OF ANY TYPE  
457 VENIPUNCTURE  
470 OBSTETRICAL  
471 PLAIN FILM  
472 ULTRASOUND GUIDANCE  
473 CT GUIDANCE

**System updating**

The following elements of the APG reimbursement system shall be updated no less frequently than annually:

- the listing of reimbursable APGs and the relative weight assigned to each APG;
- the base rates;
- the applicable ICD-9-CM codes utilized in the APG software system;
- the applicable CPT-4/HCPCS codes utilized in the APG software system; and
- the APG software system.

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Attachment 4.19-B  
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**Upper Payment Limit**

The State, in order to comply with the Upper Payment Limit (UPL) regulations at 42 CFR 447.321, will mandate the following for all clinics licensed by the NY State Department of Health, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, and the Office of Alcoholism and Substance Abuse Services.

- All clinic providers will prepare and file cost reports. The cost reports must be independently audited for cost and visit data;
- The State will issue notices to all clinic providers no later than December 31, 2009, that providers must maintain beneficiary "threshold visit" data for all payers, in a format that will be independently audited and reported on the provider's annual cost report and/or as a supplemental report for all cost reporting periods beginning on or after January 1, 2010;
- All clinic claims will be subjected to appropriate eMedNY payment edits, which will deny a claim for incorrect and/or inaccurate billing and coding information, starting no later than December 31, 2009;
- The aggregate UPL for each category of clinic (private, state owned or operated, non-state government owned or operated) will be calculated using an average cost per visit or such other method that may be authorized by CMS;
- All costs must be costs that would be allowable using Medicare cost reporting and allocation principles;
- The State will remove all costs and payments associated with services that do not meet the definition of a clinic as described in 42 CFR 440.90, for example, transportation, in-home services, etc.;
- The State will provide a progress report to Centers for Medicare and Medicaid Services (CMS) by June 30, 2011 on eMedNY editing, claims coding, and the cost reporting process;
- The State will provide an interim UPL based on 2009 data to CMS by January 1, 2012; and
- The State will submit a full UPL using 2010 cost data by June 30, 2012.

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TYPE OF SERVICE

METHOD OF REIMBURSEMENT

Ambulatory Services in Facilities  
Certified Under Article 16 of the  
State Mental Hygiene Law:

OMRDD Clinic Treatment Program  
(Programs certified by OMRDD  
pursuant to 14 NYCRR Part 679)

[Flat fee developed by OMRDD and  
approved by Division of Budget]  
For free standing out patient providers,  
OMRDD will establish statewide cost  
related flat fees. Fees will be assigned  
based on provider specific actual base  
year costs or budgets which correspond  
to the fiscal cycle of the provider. All  
fees are subject to approval by the  
Division of the Budget.

OMRDD Clinic Day Treatment Program  
(Programs certified by OMRDD  
pursuant to 14 NYCRR Part 690)

Site specific, variable, per diem  
fees, which are cost related and  
developed as follows:

Fee Setting

- (1) For the purpose of setting the Day Treatment fee, units of service shall include the total number of half day units of service (more than three hours but less than five hours), [and] the number of full day units of service (five hours or more) and less than half day units of services (such as in the amount of one and a half hour (1 1/2)). Units of service are billable in the above amounts. Billable services include the initial contact visit, [for] enrollment for completing a preliminary screening, and services for individuals formally admitted to the Day Treatment program.
- (i) Units of service for the fee setting calculation shall utilize projected or actual units of service as follows:
  - (a) For non-State operated Day Treatment programs in Regions II or III, including those programs in Region I designated or elected to a Region II or III reporting year-end and fiscal cycle, the April 1, 1991 through December 31, 1991 fee setting calculation shall utilize actual units of service from the January 1, 1988 through December 31, 1988 cost report. For non-State operated Day Treatment programs in Region I, including those programs in Regions II and III designated or elected to a Region I reporting year-end and fiscal cycle, the July 1, 1991

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to June 30, 1992 fee setting calculation shall utilize actual units of service from the July 1, 1988 through June 30, 1989 cost report. For State operated Day Treatment programs, the April 1, 1991 through March 31, 1992 fee setting calculation may utilize actual units of service from the April 1, 1989 through March 31, 1990 cost report.

(b) For the January 1, 1992 through December 31, 1992, April 1, 1992 through March 31, 1993 and July 1, 1992 through June 30, 1993 fee setting calculations, and thereafter actual units of service shall be from the [most recent] cost report submitted two years prior to the period for which the fee is being set. For programs for which OMRDD has not received such cost report at the time of the fee-setting calculation, OMRDD shall utilize the units of service paid for through the Medicaid Management Information System (MMIS) during the required cost report period.

(c) Projected units of service shall mean the estimated monthly attendance multiplied by the expected number of days the program will be open for each month. This computation shall be made for each month, [and] summed for the number of months in the fee period and annualized. Projected units of service will be used in the absence of actual units of service from cost reports identified above. Projected units of service will be required upon issuance of an operating certificate for a new site or an amended operating certificate reflecting a change in capacity. Projected units of service shall be utilized for fee-setting purposes until a full-year cost report, subsequent to the cost report period in which the issuance of an operating certificate for a new site occurred, is used for fee-setting purposes. Projected units of service shall also be utilized for fee-setting purposes until a full-year cost report, subsequent to the cost report period in which the change in capacity occurred, is utilized for fee-setting purposes. If the estimated units of service have not been received by OMRDD by the date required, OMRDD shall utilize the units of service paid for through the MMIS, beginning with the program's initial certification or the first full month since the change in certified capacity occurred. If the available MMIS units of service are for less than a twelve month period, they shall be annualized for fee-setting purposes.

(2) The fee for Day Treatment programs shall be a fixed amount plus operating, capital and transportation component add-ons. The fixed amount and operating component add-ons shall reflect base period costs and shall be subject to trend factors as approved by the commissioner. All dollar amounts cited herein shall reflect costs for the base period of January 1, 1988 through December 31, 1988.

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- (i) The operating component add-ons shall be case mix, case mix intensity, salary, staff training and utilities. In addition, non-state operated Day Treatment programs that have submitted cost reports that contain full year costs for the periods January 1, 1988 through December 31, 1988, and July 1, 1988 through June 30, 1989, and state operated Day Treatment programs which have submitted cost reports that contain full year costs for the period April 1, 1989 through March 31, 1990 shall be eligible to qualify for either a cap adjustment component add-on or an allocation adjustment component add-on. In addition, non-state operated Day Treatment programs in Regions II and III that participated in the Salary Enhancement plan pursuant to previously approved State Plan Amendment 88-48 shall also receive a salary enhancement cost adjustment component add-on. Operating component add-ons shall reflect base year costs and shall be subject to a trend factor.
- (ii) The capital component shall include property, equipment, and start-up costs. The capital component will not be subject to trend factor.
- (iii) Non-state operated Day Treatment programs in Regions II and III including those non-state operated Day Treatment programs in Region I designated or elected to a Region II or III reporting year end and fiscal cycle shall also receive an annualization cost component add-on for the period April 1, 1991 through December 31, 1991.
- (iv) The fixed amount shall be \$36.67. Effective July 1, 1996, the product of the administration component of the fixed fee times the units of service shall be reduced by an efficiency adjustment as described in this Attachment at subsection (9).
- (v) Effective July 1, 1996, there shall be a separate transportation component add-on to the program's fee as described in this Attachment at subsection (10).
- (vi) The operating component add-ons shall be computed. Such component add-ons shall be added to the fixed amount.
  - (a) Case Mix Component - The Developmental Disabilities Profile (DDP) shall be completed for each person attending the Day Treatment program. The individual's adaptive, maladaptive, and health/medical DDP scores shall be assigned as appropriate to its corresponding DDP percentile level grouping. The case mix component add-on will be calculated utilizing the

highest DDP score for each individual. Corrected or updated DDP scores shall be implemented in accordance with paragraph (5) of Attachment 4.19-B Page 3h of this State Plan. The total number of persons assigned to each percentile level grouping shall be multiplied by the dollar amount associated with that percentile level grouping. Total dollars for each percentile level shall be summed together and divided by the number of persons for whom there are DDP scores.

- (b) **Case Mix Intensity Component Add-On:** The highest single DDP percentile ranking for each individual program participant in any one of the three DDP scoring categories, adaptive, maladaptive and health/medical, shall be summed and divided by the total number of program participants with DDP scores, yielding an average percentile level grouping for each program. The Day Treatment program shall receive the per person dollar amount associated with the identified average percentile level grouping.
- (c) **Staff Training Component -** The add-on shall be \$.32.
- (d) **The Utilities Component** shall be the amount of utilities as reported in the appropriate cost report identified in paragraph (1), divided by the units of service.
- (1) The utilities amount shall reflect the costs on an annual basis trended by an amount to be determined by the commissioner.
  - (2) A day treatment program shall receive the statewide median for utilities if the most recent cost report identified by paragraph (1) is not available, or does not cover the full period of the cost report.
  - (3) Utilities may be updated to reflect actual costs and/or cost increases due to expansion of the physical plant.
- (e) **Salary Component -** The salary component of the fee shall be computed as follows:
- (1) An agency specific salary per FTE shall be computed for each agency. The agency specific salary per FTE shall be calculated as follows: For non-State operated Day Treatment programs that filed full year cost reports for either the January 1, 1988 through December 31, 1988 or July 1, 1988 through June 30, 1989, the total

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Date APR 1 - 1991

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Superseded, Title 89-33

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Supersedes TN 88-38 APR 1 - 1991

agency Day Treatment non contracted personal service costs for each Day Treatment program shall be divided by the total reported agency Day Treatment FTEs for each program and then multiplied by .9533 in order to reflect a median Day Treatment salary for each agency. The non contracted personal service costs reported on the January 1, 1988 through December 31, 1988 cost report shall be inclusive of 9 months of salary enhancement for programs that participated in the salary enhancement program of previously approved State Plan Amendment 88-48. For State operated Day Treatment programs that filed full year cost reports for the period April 1, 1989 through March 31, 1990, the statewide Day Treatment non contracted personal service costs for all state operated Day Treatment programs shall be divided by the total reported Day Treatment FTEs for all state operated Day Treatment programs and then multiplied by .9533 in order to reflect a median Day Treatment salary. The agency salary for all State operated and non-State operated programs that did not file full year cost reports, will be adjusted to reflect the agency salary of other existing Day Treatment programs operated by the provider. If the provider does not operate other Day Treatment programs, the Day Treatment agency salary shall be equal to the agency salary of ICF/DDs and/or Community Residences operated by the providers. Day Treatment agency salaries derived from other Day Treatment programs or ICF/DD and/or Community Residence programs operated by the provider shall be adjusted by .9533 to reflect a median Day Treatment agency salary. If the provider does not operate any other Day Treatment, ICF/DD or Community Residence programs, the agency salary per FTE shall be equal to the Day Treatment Statewide median salary of \$16,799. Day Treatment programs that have not filed full year cost reports for the periods identified above, will be considered to be in a Deficit (I) in accordance with item (3) below.

- (2) The agency salary per FTE shall be compared to the Day Treatment Statewide median salary of \$16,799.
- (3) Surplus/Deficit (I) - A surplus/deficit analysis shall be computed for each Day Treatment program that filed 12 month cost reports for January 1, 1988 through December 31, 1988, July 1, 1988 through June 30,

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1989, and April 1, 1989 through March 31, 1990. For non-State operated Day Treatment programs in Regions II and III and those programs in Region I elected to or designated to a Region II and III year end and fiscal cycle, the January 1, 1990 Day Treatment fixed amount and operating cost components in effect as of October 1, 1990, shall be detrended and compared to the operating costs from the January 1, 1988 through December 31, 1988 cost report. For non-State operated Day Treatment programs in Region I and those programs in Regions II or III elected to or designated to a Region I year end and fiscal cycle, the July 1, 1990 Day Treatment fixed amount and operating cost components in effect as of October 1, 1990, shall be detrended and compared to the operating costs from the July 1, 1988 through June 30, 1989 cost report. For State operated Day Treatment programs, the April 1, 1990 Day Treatment fixed amount and operating cost components, shall be detrended and compared to the operating costs from the April 1, 1989 through March 31, 1990 cost report. The surplus or deficit derived from this analysis shall be titled Surplus/Deficit (I). The Surplus/Deficit I shall not be computed for budget-based sites.

- (4) Salary component add-ons in accordance with the schedule identified below shall be added to fixed amount for each Day Treatment site.
- (i) If the agency salary per FTE pursuant to item (2)(v)(e)(1) above is greater than the 50th percentile of the statewide Day Treatment industry and the Day Treatment program is experiencing a Surplus (I) in accordance with item (2)(v)(e)(3) above, the salary component shall be \$6.10.
  - (ii) If the agency salary per FTE pursuant to item (2)(v)(e)(1) above is greater than the 50th percentile of the Day Treatment industry and the Day Treatment program is experiencing a Deficit (I) in accordance with item (2)(v)(e)(3) above, the salary component shall be \$6.10 plus the amount of costs equal to the agency salary per FTE divided by the Statewide salary of \$16,799 multiplied by \$29.09, minus \$29.09. 21.2 percent fringe is added to this amount.

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- (iii) If the adjusted agency salary per FTE pursuant to item (2)(v)(e)(1) above is greater than the 40th percentile or equal to the Day Treatment Statewide salary of \$16,799, the salary component add on shall be \$6.10.
  - (iv) If the adjusted agency salary per FTE pursuant to item (2)(v)(e)(1) above is equal to or greater than the 30th percentile or less than the 40th percentile of the Day Treatment industry, the salary component add on shall be \$3.89.
  - (v) If the adjusted agency salary per FTE pursuant to item (2)(v)(e)(1) above is equal to or greater than the 20th percentile or less than the 30th percentile of the Day Treatment industry, the salary component add on shall be \$2.37.
  - (vi) If the adjusted agency salary per FTE pursuant to item (2)(v)(e)(1) above is equal to or greater than the 10th percentile or less than the 20th percentile of the Day Treatment industry, the salary component add on shall be \$1.50.
  - (vii) If the adjusted agency salary per FTE pursuant to item (2)(v)(e)(1) above is less than the 10th percentile of the Day Treatment industry, the salary component add on shall be \$0.
- (f) Salary Enhancement Cost Adjustment Component Add-On - The fixed amount for non-State operated Day Treatment programs that participated in the salary enhancement plan pursuant to previously approved State Plan Amendment 88-48 during the period April 1, 1988 through December 31, 1988 and submitted a 12 month cost report for the same period, shall receive a salary enhancement cost adjustment component add-on. Budget based Day Treatment programs in Regions II and III whose agency salary per FTE pursuant to item (2)(v)(e)(1) above, is equal to the agency salary of other existing Day Treatment programs operated by the same provider shall also receive the salary enhancement cost adjustment component add-on. The salary enhancement cost adjustment component may be revised to reflect additional FTEs for programs that have experienced a capacity change resulting in the issuance of a new operating certificate.

- (1) The salary enhancement cost adjustment component shall be calculated as follows:
- (i) For Day Treatment programs in Region II, the total number of direct care and support FTEs shall be multiplied by 25 percent of \$1,900 and increased by a fringe benefit factor of .212 percent and divided by the units of service pursuant to paragraph (1).
  - (ii) For Day Treatment programs in Region III, the total number of direct care and support FTEs shall be multiplied by 25 percent of \$1,690 and increased by a fringe benefit factor of .212 percent and divided by the units of service pursuant to paragraph (1).
- (g) Cap adjustment component add-on and allocation adjustment component add-on.
- (1) In order to determine eligibility for either the Cap Adjustment Component add-on or the Allocation component add-on, a surplus/deficit analysis shall be computed for each Day Treatment program using operating fees determined in accordance with subparagraphs (2)(iv) and (v)(a) - (f) [and the actual units of service from the appropriate 1988 cost report for non state operated programs and the April 1, 1989 through March 31 1990 cost report units of service for state operated programs. As appropriate, operating fee revenues shall be compared to appropriate adjusted program specific operating costs from either the January 1, 1988 through December 31, 1988 or July 1, 1988 through June 30, 1989 or the April 1, 1989 through March 31, 1990 cost reports. The surplus or deficit derived from this analysis shall be titled Surplus/Deficit (II).
  - (2) Day Treatment programs determined to be in a Deficit (II) pursuant to subclause (1) above that received salary components in accordance with items subclause (2)(v)(e)(4)(i) shall receive a cap adjustment component equal to the Deficit (II) divided by the units of service.
  - (3) Day Treatment programs determined to be in a Deficit (II) pursuant to clause (1), that received salary components in accordance with items (2)(v)(e)(4)(iii) through (vii) shall receive an allocation component equal to \$3.07.

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(h) The capital component add-on shall be the amount of allowable capital costs and start-up costs divided by the units of service figure. Such allowable capital costs and start-up costs must be in accordance with subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, in the ICF/DD portion of this Plan, and subdivision (k) Glossary, also in the ICF/DD portion of this Plan. [ may include the cost of principal and interest payments on loan from the NYS Facilities Development Corporation (hereinafter referred to as FDC) pursuant to subdivision 13-d of section 5 of the Facilities Development Corporation Act, net of the portion of such payments attributable to operating costs; provided that the reimbursement of FDC loan payments is an allowance in lieu of reimbursement of interest and depreciation associated with the mortgaged property and/or in lieu of reimbursable start-up costs and in lieu of reimbursement for other underlying allowable costs for which the FDC loan was received. A provider which receives an FDC loan pursuant to subdivision 13-d of section 5 of the Facilities Development Corporation Act, does not have the option of having included in the calculation of its rate otherwise allowable interest, depreciation, start-up costs, or the loan's underlying costs instead of the allowance representing principal and interest. Capital costs and s] Start-up costs shall be from the best available and documented data that reflects the cost expected to be incurred during the fee period.[ For property acquired or leased on or after January 1, 1986 prior approval by Office of Mental Retardation and Developmental Disabilities and the Division of the Budget shall be required in order for such property costs to be reimbursed in the fee.] At the onset of each fee period, the OMRDD shall review the capital component add-on for substantial material changes. If said changes are allowable, the capital component shall be revised.

(3) For the January 1, 1991 to December 31, 1991, April 1, 1991 to March 31, 1992 and the July 1, 1991 to June 31, 1992 fee periods, the final fee shall be equal to the capital component calculated in accordance with (h) above plus the greater of (i) or (ii) below. For the January 1, 1992 to December 31, 1992, April 1, 1992 to March 31, 1993 and the July 1, 1992 to June 31, 1993 fee periods, and thereafter, the final fee shall be equal to the property and equipment component calculated in accordance with clause (h) of this state plan plus subparagraph (ii) of this paragraph:

(i) For non-State operated programs in Region I and those non-State operated programs designated or elected to a region I year end and fiscal reporting cycle, 99.5 percent of the fixed fee and operating components contained in the June 30, 1991 fee trended to the July 1, 1991 to June 30, 1992 fee period. For non-State operated programs in Regions II and III and those non-State operated programs designated or elected to a Region II or III year end and fiscal reporting cycle, 99.5 percent of the fixed fee and operating components contained in the December 31, 1990 fee trended to the January 1, 1991 to December 31, 1991 fee period. For State operated programs, 99.5 percent of the fixed fee and operating components contained in the March 31, 1991 fee trended to the April 1, 1991 through March 31, 1992 fee.

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- (ii) The fixed fee and operating components determined in accordance with subsection (2) of this State Plan trended to the appropriate fee period.
- (4) The final adjusted fee shall be equal to the final fee determined in subsection (3) above except as provided below as follows:
- (i) Non-state operated Day Treatment programs in Regions II and III including those programs in Region I designated or elected to a Region II and III year-end reporting and fiscal cycle shall receive the annualization component add-on for the period April 1, 1991 to December 31, 1991. The annualization component add-on shall be equal to the difference between the fee in effect on March 31, 1991 and the April 1, 1991 final fee calculated pursuant to subsection (3) for the period January 1, 1991 to March 31, 1991 divided by the units of service pursuant to subsection (1). The annualization component add-on shall be added to the final fee determined in accordance with subsection (3) above, and the resulting fee shall be considered the final adjusted fee.
- (ii) The final adjusted fee for non-state operated Day Treatment programs in Region I and those facilities designated or elected to a Region I year-end fiscal cycle and state operated Day Treatment programs shall be equal to the final fee determined in accordance with subsection (3) above.
- (iii) For eligible facilities, the final fee shall be adjusted to include an amount in accordance with subsections (10) and (11).
- (5) The commissioner may make corrections to the fees based upon the following:
- (i) Errors which occurred in the computation of the fee.
- (ii) Final audit findings.
- (iii) The Day Treatment provider may request corrections to the fee within 90 days of receipt of the fee. Such corrections are limited to errors in the cost report and corrections to the DDP. If corrections to the DDP would result in an increase to the final adjusted fee, the commissioner may independently review the corrected DDPs. During the period when the commissioner is reviewing the provider-submitted revised DDP data, the DDP in the fee at the time of review shall remain in effect. Should the commissioner's review verify the provider-submitted revisions to the DDP data, said revised DDP data shall be utilized for fee-setting purposes retroactive to the first day of the fee period. The case mix component add-on and the case mix intensity component add-on may be recalculated only if there is a 10 percent or greater change in participants resulting from either a change in certified capacity or a turnover in program participants, or a correction to the DDP score approved by the commissioner. Day Treatment providers must report to OMRDD Rate Setting all participant changes greater than 10 percent.

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- (iv) Corrections to the transportation component add-on pursuant to subsection (10) of Attachment 4.19-B of this State Plan.
- (v) Adjustment to actual units of service.
  - (a) OMRDD may, upon request from a Day Treatment provider, adjust the units of service used for the program's calculation for the prior fee period to actual units of service delivered during such fee period. However, such adjustment will be limited to situations where the Day Treatment provider demonstrated the Day Treatment program was in a deficit situation for the prior fee period and had for reasons beyond its control not been able to deliver the units of service used to calculate the fee for the prior fee period.
  - (b) The Day Treatment provider must request adjustments to the program's actual units of service within [90] 150 days of the close of the [fee] fiscal reporting period for which the said adjustment is sought.
- (6) All fees and any corrections to fees shall not be considered final unless approved by the director of the Division of Budget.
- (7) To encourage the closure of developmental centers, the commissioner will consider proposals to allow the variable costs associated with the closed center or center to become part of the operating expenses of new or existing state operated Day Treatment programs. The commissioner will allow a reasonable incentive plan for the reimbursement of the increased costs referred to above in state operated Day Treatment programs if it is coupled with the closure of a developmental center. An incentive plan would provide for the reimbursement in total of closure related increased costs in the state operated Day Treatment programs without adjustment or offsets.
  - (i) The following reimbursement schedule will be used for proposals approved by the commissioner:
    - (a) 100% reimbursement of the increased cost for at least one full fee period but less than two full fee periods.
    - (b) 75% reimbursement of the increased cost for the second full fee period following the period defined in subsection (7)(i)(a) above.
    - (c) 50% reimbursement of the increased cost for the third full fee period.
    - (d) 25% of the increased cost for the fourth full fee period.

- (ii) Costs to be eligible for this incentive plan will include but not be limited to direct care, support and clinical personal service and fringe benefit amounts for employees whose most recent prior employment was at a closed or scheduled to close developmental center.
- (a) In order to have the cost of a former developmental center employee included in the incentive plan, the state operated [facility] Day Treatment program applying for a fee adjustment pursuant to subsection (7) must hire such employee within twelve months of the official closing date of the developmental center.
- (b) Salaries and fringe benefit amounts paid to eligible employees by the new program may not exceed the average salary and fringe amounts paid to comparable employees currently on that [facility's] payroll.
- (c) Any claim made under this provision is subject to audit as noted in section (5)(ii).
- (iii) Incentive plan applications shall be made in writing to the commissioner.
- (a) The application shall identify the employees, their job titles, salary levels, date hired, and the B/DDSO of previous employment.
- (b) OMRDD may request such additional information as it deems necessary.
- (8) To accelerate the closure and to encourage a reduction in the size of developmental centers, the commissioner will consider proposals to allow the variable costs associated with a developmental center to become part of the operating expenses of new and existing state operated Day Treatment programs. The variable costs associated with the developmental center will be allowed for the transition which is the period beginning on the date an official announcement to close a [facility or facilities] center or centers and ending on the date of actual closure. Also variable costs associated with the conversion of beds which is a substantial material change in the [facility] center census will be allowed. The commissioner will allow a reasonable incentive for the reimbursement of the increased costs referred to above in the state operated [community facilities] Day Treatment programs during the transition and/or conversion period.
- (i) The commissioner will allow the following reimbursement for approved proposals:

- (a) 75% reimbursement of the increased costs incurred during the transition[al] closure period. On the effective date of closure, reimbursement of increased costs will be considered under subsection (7).
  - (b) 75% reimbursement of the increased costs incurred during the conversion period. The conversion period will be for at least one full fee period but less than two full fee periods. If during the conversion period, an official announcement of closure occurs, the reimbursement of increased costs may be considered under subsection (7)(i)(a).
- (ii) Costs to be eligible for this incentive plan will include but not be limited to direct care, support and clinical personal service and fringe benefit amounts for employees whose most recent prior employment was at a closed or scheduled to close developmental center.
- (a) In order to have the cost of a former developmental center employee included in the incentive plan, the [community facility] Day Treatment program applying for a fee adjustment pursuant to subsection (7)(iv) must hire such employee during the transition[al] and conversion periods.
  - (b) Salaries and fringe benefit amounts paid to eligible employees by the [facility] Day Treatment program cannot exceed the average salary and fringe benefit amount paid to comparable employees currently on that [facility's] program's payroll.
  - (c) Any claim made under this provision is subject to audit as noted in section (5)(ii).
- (iii) Incentive plan applications from the provider shall be made in writing to the commissioner.

- (9) Effective July 1, 1996, there shall be an efficiency adjustment as described herein and applied as a reduction to the fixed component of the fee.
- (i) The efficiency adjustment shall be a percentage reduction based on the \$10.12 associated with administration in the fixed component of the fee. Except as provided for in (ii) of subsection (9) of this section, all cost and revenue information, used to determine the efficiency adjustment percentages, shall be based on reported cost and revenue information for the calendar 1992 or 1992-93 cost reporting year. Each provider shall be assigned a percentage value from the table at subclause (3) of this clause, based on total program cost, a program surplus/deficit group designation and an administration percentage group designation.
- (a) Determination of program surplus/deficit group. A determination shall be made as to whether each provider has a program surplus or deficit, for the combined total of all community residence and Day Treatment programs and all residential habilitation and day habilitation services. Surplus/deficit shall equal gross revenue (less any prior period adjustments) minus allowable costs.
- (1) For those providers with a reported deficit, this deficit shall be considered the final deficit amount for the purpose of this calculation.
- (2) For those providers with a reported program surplus, a certain portion of that surplus shall be exempted to establish an adjusted surplus. The adjusted surplus shall be the reported surplus minus the exempt amount. Exempt amounts shall be determined as follows. For providers whose total program costs are:
- (i) less than \$1 million, the exempt amount shall be \$10,000.
- (ii) between \$1 million and less than \$3 million, the exempt amount shall be \$22,500.
- (iii) between \$3 million and \$7 million, the exempt amount shall be \$35,000.
- (iv) over \$7 million, the exempt amount shall be \$40,000.

- 3h4 -

TN 96-39

DEC 19 1996

Supersedes New Date JUL 01 1996

- (3) The reported deficit or the adjusted surplus shall be given one of the following designations used to determine the efficiency adjustment percentage in the table at the end of this section:
- (i) \$2 if the adjusted surplus is equal to or greater than \$200,000.
  - (ii) S1 if the adjusted surplus is from \$20,000 to \$199,999.
  - (iii) BE if the reported deficit is not greater than (\$19,999) or the adjusted surplus is not greater than \$19,999 (BE - break even).
  - (iv) D1 if the reported deficit is from (\$20,000) to (\$199,999).
  - (v) D2 if the reported deficit is equal to or greater than (\$200,000).

- (b) Determination of a calculated administration percentage group. A determination shall be made of a provider's calculated administration cost, where administration percentage shall equal administration divided by the result of total operating cost minus the sum of capital costs and administration. There shall be five group designations that express the calculated administration percentage as a departure from the average percentage for all provider agencies. Those percentages centered around the average are designated with the abbreviation AVG. There are also two group designations for percentages over the average, abbreviated OA2 and OA1 and two designations for under the average, abbreviated UA2 and UA1. These abbreviations appear in the table of percentages at the end of this section as well as in the following regional tables. Each provider's assignment to one of the five group designations shall be based on the provider's calculated administration percentage, total program cost and elected or assigned region (refer to subdivision (a) of this section). Each provider's administration percentage group designation shall be determined using the following tables.

REGION ONE

Program Cost in Millions of Dollars (< less than; > greater than)

<u>&lt; \$1</u>	<u>\$1 to &lt; \$3</u>	<u>\$3 to \$7</u>	<u>&gt; \$7</u>	<u>Group</u>
<u>Administration Percentage</u>				
<u>.3100 PLUS</u>	<u>.4500 PLUS</u>	<u>.4500 PLUS</u>	<u>.4500 PLUS</u>	<u>OA2</u>
<u>.2600 .3099</u>	<u>.3500 .4499</u>	<u>.3500 .4499</u>	<u>.3500 .4499</u>	<u>OA1</u>
<u>.2300 .2599</u>	<u>.3200 .3499</u>	<u>.3200 .3499</u>	<u>.2800 .3499</u>	<u>AVG</u>
<u>.1900 .2299</u>	<u>.2500 .3199</u>	<u>.2400 .3199</u>	<u>.2400 .2799</u>	<u>UA1</u>
<u>.0000 .1899</u>	<u>.0000 .2499</u>	<u>.0000 .2399</u>	<u>.0000 .2399</u>	<u>UA2</u>

REGION TWO

Program Cost in Millions of Dollars (< less than; > greater than)

<u>&lt; \$1</u>	<u>\$1 to &lt; \$3</u>	<u>\$3 to \$7</u>	<u>&gt; \$7</u>	<u>Group</u>
<u>Administration Percentage</u>				
<u>.3100 PLUS</u>	<u>.4500 PLUS</u>	<u>.3500 PLUS</u>	<u>.3500 PLUS</u>	<u>OA2</u>
<u>.2900 .3099</u>	<u>.3500 .4499</u>	<u>.2800 .3499</u>	<u>.2500 .3499</u>	<u>OA1</u>
<u>.2150 .2899</u>	<u>.3200 .3499</u>	<u>.2500 .2799</u>	<u>.1900 .2499</u>	<u>AVG</u>
<u>.1900 .2149</u>	<u>.2500 .3199</u>	<u>.2000 .2499</u>	<u>.1700 .1899</u>	<u>UA1</u>
<u>.0000 .1899</u>	<u>.0000 .2499</u>	<u>.0000 .1999</u>	<u>.0000 .1699</u>	<u>UA2</u>

REGION THREE

Program Cost in Millions of Dollars (< less than; > greater than)

<u>&lt; \$1</u>	<u>\$1 to &lt; \$3</u>	<u>\$3 to \$7</u>	<u>&gt; \$7</u>	<u>Group</u>
<u>Administration Percentage</u>				
<u>.4200 PLUS</u>	<u>.3500 PLUS</u>	<u>.2800 PLUS</u>	<u>.4200 PLUS</u>	<u>OA2</u>
<u>.3300 .4199</u>	<u>.2700 .3499</u>	<u>.2550 .2799</u>	<u>.3300 .4199</u>	<u>OA1</u>
<u>.2400 .3299</u>	<u>.2250 .2699</u>	<u>.2300 .2549</u>	<u>.2400 .3299</u>	<u>AVG</u>
<u>.1851 .2399</u>	<u>.1900 .2249</u>	<u>.2100 .2299</u>	<u>.1851 .2399</u>	<u>UA1</u>
<u>.0000 .1850</u>	<u>.0000 .1899</u>	<u>.0000 .2099</u>	<u>.0000 .1850</u>	<u>UA2</u>

(c) Determination of the efficiency adjustment percentage. Each provider shall be assigned an efficiency adjustment percentage value from the following table, based on the surplus/deficit group designation and the administration percentage group designation. The amount associated with the administration component of the fixed fee shall be determined by multiplying the administration component of the fixed fee times the units of service. The resulting total amount shall then be reduced by an efficiency adjustment percentage.

	<u>S2</u>	<u>S1</u>	<u>BE</u>	<u>D1</u>	<u>D2</u>
<u>OA2</u>	<u>17.00%</u>	<u>16.00%</u>	<u>15.00%</u>	<u>14.00%</u>	<u>13.00%</u>
<u>OA1</u>	<u>16.25%</u>	<u>15.25%</u>	<u>14.25%</u>	<u>13.25%</u>	<u>12.25%</u>
<u>AVG</u>	<u>15.50%</u>	<u>14.50%</u>	<u>13.50%</u>	<u>12.50%</u>	<u>11.50%</u>
<u>UA1</u>	<u>14.75%</u>	<u>13.75%</u>	<u>12.75%</u>	<u>11.75%</u>	<u>10.75%</u>
<u>UA2</u>	<u>14.00%</u>	<u>13.00%</u>	<u>12.00%</u>	<u>11.00%</u>	<u>10.00%</u>

(1) If a provider agency opens a new Day Treatment program subsequent to the 1992 or 1992-93 cost reporting period, the cell value designated for the new Day Treatment program, shall be the same cell value as that which is designated for all of the provider's other Day Treatment programs, and for which 1992 or 1992-93 cost data are available.

(2) New agencies operating Day Treatment programs subsequent to the 1992 or 1992-93 cost reporting period shall be assigned the center cell value, i.e., AVG-BE, in the table found in this subclause.

(ii) A provider may request that OMRDD use a more recent cost reporting period, as an alternative to the 1992 or 1992-93 reporting period, to determine the efficiency adjustment percentage as described herein. Approval to use an alternative reporting period shall be granted if, upon a fiscal review by the commissioner, it is determined that the cost report for the alternative reporting period more accurately reflects the provider's current financial status. For the purpose of determining the efficiency adjustment percentage only, providers may submit corrections to their 1992 or 1992-93 cost report. Such corrections shall be certified by a certified public accountant. Providers may request the use of an alternative reporting period or may submit corrections to their 1992 or 1992-93 cost report only once. Such requests or corrections shall be made in writing and received by OMRDD by December 31, 1996. Providers shall also have until December 31, 1996 to notify OMRDD of errors made in calculating the efficiency adjustment.

(10) Effective July 1, 1996, there shall be a separate transportation component add-on to the program's fee. This component add-on for each Day Treatment program shall be determined using the following methodology.

(i) Using a payment/rate data sample from calendar years 1995 and 1996, the weighted transportation average shall be calculated by dividing the aggregate transportation payments by the aggregate transportation units of service on a program specific basis. One round trip shall equal one unit of service.

(a) The weighted transportation average for each Day Treatment program shall be ranked among all Day Treatment programs statewide.

(i) If a program's weighted transportation average is \$11.16 or less, the weighted transportation average shall be held 100 percent harmless.

(ii) If a program's weighted transportation average exceeds \$11.16, forty percent of the weighted transportation average shall be held harmless.

(b) After deducting the forty percent to be held harmless, the net weighted transportation average for each program (i.e., the remaining 60 percent of the weighted transportation average) shall be re-ranked. Based on the new percentile rankings, a percentage offset shall be deducted from the net weighted transportation average. A program's percentage offset shall be determined by locating its net weighted transportation average (i.e., the remaining 60 percent of the weighted transportation average) in the following table.

<u>PERCENTILE RANK</u>	<u>NET WEIGHTED TRANSPORTATION AVERAGE</u>	<u>PERCENTAGE OFFSET</u>
<u>5 or &lt;</u>	<u>\$0 - \$7.26</u>	<u>5</u>
<u>6 to 9</u>	<u>\$7.27 - \$8.13</u>	<u>7.5</u>
<u>10 to 29</u>	<u>\$8.14 - \$10.20</u>	<u>10</u>
<u>30 to 49</u>	<u>\$10.21 - \$13.32</u>	<u>12.5</u>
<u>50 to 59</u>	<u>\$13.33 - \$13.80</u>	<u>15</u>
<u>60 to 69</u>	<u>\$13.81 - \$14.01</u>	<u>16.5</u>
<u>70 to 79</u>	<u>\$14.02 - \$14.97</u>	<u>20</u>
<u>80 to 84</u>	<u>\$14.98 - \$15.77</u>	<u>22.5</u>
<u>85 or &gt;</u>	<u>Over \$15.77</u>	<u>25</u>

- (c) The amount remaining after the application of the percentage offset (the sixty percent of the weighted transportation average reduced by the offset percentage in the table above) shall be added to the hold harmless amount to determine a program's modified weighted transportation average.
- (1) If the modified weighted transportation average falls below \$11.16, the modified weighted transportation average shall be adjusted to \$11.16.
- (2) If the modified weighted transportation average exceeds \$30.00, the modified weighted transportation average shall be adjusted to \$30.00.
- (d) The modified weighted transportation average shall be multiplied by the total to and from Day Treatment transportation units and divided by the total Day Treatment units of service to create a Day Treatment transportation component add-on. This shall be a separate component added to the Day Treatment fee.
- (ii) If an agency currently providing Day Treatment does not have to and from transportation payment/rate data available for a particular program for the period used to calculate the modified weighted transportation averages, or if a provider agency opens a new Day Treatment program, the modified weighted transportation average shall be equal to the lesser of:
- (a) the new program's budgeted amount for transportation based on the transportation requirements of the person(s) to be transported to and from the new Day Treatment program, or
- (b) the average of the modified weighted transportation averages for all other Day Treatment programs operated by the provider agency.
- (iii) If a provider agency does not currently operate a Day Treatment program and opens a new Day Treatment program, or if a provider agency does not have to and from transportation payment/rate data for any of its Day Treatment programs for the period used to calculate the modified weighted transportation averages, the modified weighted transportation average shall be equal to the lesser of:
- (a) the new program's budgeted amount for transportation based on the transportation requirements of the person(s) to be transported to and from the Day Treatment program, or
- (b) the average of the modified weighted transportation averages for all day habilitation programs operated by the provider agency in accordance with the State's Home and Community Based Services Waiver for persons with mental retardation and developmental disabilities.

(iv) If the provider agency does not operate any Day Treatment program or day habilitation program, the modified weighted transportation average shall be equal to the lesser of the new Day Treatment program's budgeted amount for transportation based on the transportation requirements of the person(s) to be transported to and from the Day Treatment program or 75 percent of the regional modified weighted transportation average associated with transporting individuals to and from Day Treatment programs. The table below shows the regional modified weighted transportation averages:

<u>REGION</u>	<u>AVERAGE</u>	<u>75 PERCENT OF AVERAGE</u>
1	\$21.37	\$16.03
2	\$21.17	\$15.88
3	\$15.97	\$11.98

(v) Providers that operated only day habilitation programs, under the Home and Community Based Services Waiver, prior to July 1, 1996, and opened a Day Treatment program for the first time between July 1, 1996 and September 26, 1996 and received 75 percent of the regional modified weighted transportation average for day treatment transportation as the transportation add-on component to the Day Treatment fee, shall receive a one time fee adjustment based on the methodological change that became effective on September 26, 1996 as described paragraph (10)(iii) above. The one time fee adjustment shall be either:

- (a) a one time fee increase if the provider's fee effective July 1, 1996 was lower than the new fee effective September 26, 1996, because the lesser of the need-based budgeted transportation amount or the average of the provider agency's day habilitation modified weighted transportation averages is greater than 75 percent of the regional modified weighted average for transportation to and from day treatment, or
- (b) a one time fee decrease if the provider's fee effective July 1, 1996 was higher than the new fee effective September 26, 1996, because the lesser of the need-based budgeted transportation amount or the average of the provider agency's day habilitation modified weighted transportation averages is less than 75 percent of the regional modified weighted average for transportation to and from day treatment.

- (11)(i) Effective January 1, 1999 for non-state operated facilities, a cost of living add-on may be included in the final adjusted fee. This add-on will be an increase to the fee due to a 2.5 percent increase in salaries and salary related fringe benefits. Inclusion of the add-on is subject to a resolution of the facility's governing body that funding received will be used solely to effect a 2.5 percent increase beginning with the lowest paid employees. To be deemed reimbursable, both the resolution and an implementation plan must be submitted by the facility and approved by the commissioner.
- (ii) Effective January 1, 1999, for state operated facilities, a cost of living add-on will be included in the final adjusted fee. This add-on will be the full annual amount of 2.5 percent of the salaries and salary related fringe benefits included in the final fee.
- (iii) Facilities certified as day treatment facilities on or after May 20, 1999 shall be deemed to have met the requirements for an approved cost of living add-on described in paragraphs (i) and (ii) of this paragraph, and a corresponding factor shall be included in the final adjusted fee.
- (iv) Effective July 1, 2000 non-state operated facilities may be eligible for a salary enhancement add-on to be included in their final net fee. This add-on will recognize the costs of a \$750 annual salary increase per full time equivalent, plus salary related fringe benefits, for direct care and support workers. Inclusion of the add-on is subject to a resolution of the facility's governing body that funding received will be used solely to effect this increase. To be deemed reimbursable, both the resolution and an implementation plan must be submitted by the facility and approved by the commissioner.

TN 00-35 Approval Date JUN 06 2000  
 Supersedes TN 99-20 Effective Date JUL 01 2000

-3h12

- (v) Effective July 1, 2000, for state operated facilities, a salary enhancement add-on will be included in the final adjusted fee. This add-on will be the full annual amount of \$750 per full time equivalent, plus salary related fringe benefits, for the direct care and support full time equivalent included in the final fee.
- (vi) Facilities initially certified as day treatment facilities on or After April 1, 2001 shall be deemed to have met the requirements for an approved salary enhancement add-on described in subparagraphs (iv) and (v) of this paragraph, and a corresponding factor shall be included in the final adjusted fee.
- (vii) Effective January 1, 2003, non-state operated facilities may be eligible for a cost of living adjustment (COLA) add-on of three percent to be included in their final adjusted fee. This add-on is a three percent increase to the personal service portion of allowed reimbursement, for expenditures related to recruitment and retention of staff for the period of April 1, 2002 through March 31, 2003. On or after January 1, 2003, eligible facilities will receive an amount that they would have received if the COLA add-on were added to the final adjusted fee on December 1, 2002. The provider is required to submit to OMRDD a Letter of Attestation, signed by the Executive Director and President or equivalent of the governing body, which details how the COLA is expended.
- (viii) Effective January 1, 2003, for state operated facilities, a cost of living adjustment (COLA) add-on of three percent is included in the final adjusted fee. This add-on is a three percent increase to the personal service portion of allowed reimbursement, for expenditures related to recruitment and retention of staff for the period of April 1, 2002 through March 31, 2003. On or after January 1, 2003 facilities will receive an amount that they would have received if the COLA add-on were added to the final adjusted fee on December 1, 2002.
- (ix) Facilities certified on or after April 1, 2003 shall be deemed to have met the requirements for an approved COLA add-on described in subparagraphs (vii) and (viii) of this paragraph, and a corresponding factor shall be included in the final adjusted fee.
- (x) The day treatment facility shall be responsible for the cost of services which:
- (a) are necessary to meet the needs of consumers while attending the program, and
- (b) which prior to August 1, 2004 could have been met by home health aide or personal care services separately billed to Medicaid.

TN# 05-08Approval Date: DEC 12 2005

Supercedes TN#: \_\_\_\_\_

Effective Date: JAN 5 2005

New York  
3 (i)

Attachment 4.19-B  
(04/02)

Type of Service      [Method of Reimbursement]

Office of Alcoholism And Substance Abuse Services (OASAS) Outpatient Services

Chemical Dependence Medically Supervised Treatment and Chemical Dependence Medically Supervised Withdrawal Services

For dates of service beginning on July 1, 2002, facilities certified solely under article 32 of the Mental Hygiene Law will be reimbursed based upon per visit fees developed by the Department of Health and approved by the Division of the Budget. Fees will be prospective, all-inclusive, and will be based upon reported historical cost and visit data supplied by providers. Operating and capital cost data is submitted annually on the facility Consolidated Fiscal Report (CFR). Fees are regionally adjusted to reflect geographic cost variation and are based upon 1998 base year cost data trended to this initial level.

[DAAA (Clinic Treatment and Day Rehabilitation)]

[Flat fee developed by DAAA and approved by the Division of the Budget]

**OMH Outpatient Programs Licensed Under 14 NYCRR Parts 579 and 585: (to be phased out)**

**Clinic, Day and Continuing Treatment Programs**

For freestanding outpatient providers OMH will establish regional fee schedules which recognizes regional cost differences. For hospital-based providers, OMH will establish cost-related rates subject to ceiling limitations. All fees and rates are subject to the approval of the Division of the Budget.

In addition to these fees, a provider which has been recommended by the local governmental unit and designated by the New York State Office of Mental Health can receive a supplemental rate for clinic and/or day treatment programs to cover the cost of additional rehabilitative services provided by its community support program(s). Such rates shall be calculated by dividing the cost of community support program services determined to be eligible for Medicaid reimbursement by the number of services provided to recipients who are eligible for Medicaid.

TN 02-16 Approval Date AUG 09 2002  
Supersedes TN 97-39 Effective Date JUL 01 2002

**Type of Service**

OMH Outpatient Programs Licensed Under 14 NYCRR Parts 587 and 588 (to replace existing programs licensed under 14 NYCRR Parts 585 and 579

Clinic Treatment for Adults, Clinic Treatment for Children, Clinic and Continuing Day Treatment Programs

**Method of Reimbursement**

For Freestanding outpatient providers OMH will establish regional fee schedules which recognize regional cost differences. For hospital based providers, OMH will establish cost related rates subject to ceiling limitations. All fees and rates are subject to the approval of the Division of the Budget.

Continuing Day Treatment fees will be tiered so that a client's reimbursement will vary depending on their service utilization during a month. The fee will decrease when a client reaches specified, uniform monthly utilization levels. Freestanding outpatient providers will have three fees representing three utilization levels. Hospital based providers will have two.

In addition to these fees, a provider which has been recommended by the local governmental unit and designated by the New York State Office of Mental Health can receive a supplemental rate for clinic and/or continuing day treatment programs to cover the cost of additional rehabilitative services provided by its community support program(s). Such rates shall be calculated by dividing the cost of community support program services determined to be eligible for Medicaid reimbursement by the number of services provided to recipients who are eligible for Medicaid.

OMH will also set project specific fees for approved projects which examine innovative program and administrative configurations, subject to the approval of the Division of the Budget.

TN 98-28

Approval Date

DEC 9 1990

Supersedes TN 90-48

Effective Date

AUG 1 1990

Type of Service

Method of Reimbursement

Clinic Treatment for Adults, Clinic  
Treatment for Children, Clinic  
Continuing Day Treatment Programs

Effective April 1, 2000, OMH will increase the fees paid to certain not-for-profit outpatient and non-residential programs which are not eligible for reimbursement as comprehensive outpatient programs under the regulations of the Office of Mental Health; and will also increase fees for programs which are designated as comprehensive outpatient programs but absent such fee increase would not be reimbursed at a rate equivalent to the non-comprehensive programs. In return for these fee increases, the non-comprehensive programs will be required to perform additional case management functions, must agree to provide emergency response services for cases deemed "critical", participate in conjunction with other mental health providers in the local planning process set forth in State laws and regulations and provide other additional services as required by OMH. In no instance will these programs be required to perform services greater than those performed by programs designated as comprehensive outpatient programs.

TN 00-23 Approval Date SEP 12 2000  
Supersedes TN New Effective Date APR 1 - 2000

TYPE OF SERVICE

METHOD OF REIMBURSEMENT

Partial Hospitalization

OMH will establish regional fee schedules which recognize regional cost differences. All fees are subject to approval by the Division of the Budget. There will be limits on the number of service hours reimbursed per individual for each service episode and for a calendar year.

Comprehensive Outpatient Programs - 14 NYCRR Part 592

OMH will develop provider specific rate supplements to fees [detailed in 14 NYCRR Parts 579 and 588] for outpatient mental health programs licensed exclusively by OMH and rates promulgated by OMH for outpatient mental health programs operated by general hospitals and licensed by OMH based upon expenditures approved by OMH to outpatient programs licensed pursuant to 14 NYCRR Parts 585 and 587 [who] which are designated by county mental health departments or OMH.

TN 92-30

Approval Date JUL 30 1992

Supersedes TN 91-32 Effective Date APR 1 1992

**TYPE OF SERVICE**

**Intensive Psychiatric Rehabilitation Treatment**

OMH will develop a flat fee to be approved by the Division of Budget. There will be limits on the number of monthly and calendar year service hours that may be reimbursed per individual. Off-site service reimbursement will all be limited to a percentage of each program's total service hours.

**Rehabilitative Services for Residents of Community-based Residential Programs Licensed by the Office of Mental Health**

OMH will develop monthly and half-monthly rates for OMH licensed community-based residences of sixteen (16) or fewer beds to provide physician-prescribed rehabilitation services for seriously mentally ill individuals in residences. OMH will develop rates for services provided to eligible residents of congregate-type community residences for both children and adults, apartment-based community residences for adults, family-based treatment programs for children and teaching family homes for children. Rehabilitation services will not include didactic education, vocational services, and room and board.

**Program Type 1:**

- 1) Community Residences

**Program Categories**

- a) congregate-type
- b) apartment-based

**Program Type 2:**

- 1) Family Based Treatment

**Program Type 3:**

- 1) Teaching Family Homes

Providers of rehabilitation services shall be assigned an individual provider monthly rate based upon their cumulative approved costs for all sites divided by the maximum capacity for their sites divided by 12 months, divided by the specific utilization factor established by the Office of Mental Health for beds in adult congregate programs (85%), adult apartment programs (83%) or for children's residential services programs (82%). Rates for a half month service shall be 50% of the monthly rate. The rate calculated under this methodology will be reduced by \$4 for a full month and \$2 for a half month rate to account for payment for the four individual Rehabilitation Services at a cost of \$1.00 per service required for a full month and two individual Rehabilitation Services at a cost of \$1.00 per service required for a half month.

The rate methodology for rehabilitation services provided in residential programs operated by the Office of Mental Health shall be the same as for other licensed providers except that there shall be one statewide rate which shall be the lower of the calculated rate or the highest rate approved for other providers.

**TN 96-21**

**SEP 23 1996**

Supersedes TN 94-27 Effective Date **MAY 01 1996**

**OFFICIAL**

New York

Attachment 4.19- B

Page 3L-1

TYPE OF SERVICE

Personalized Recovery Oriented Services:  
(PROS)  
Community Rehabilitation and Support

Providers will be reimbursed through a regionally based, tiered monthly case payment, based on the number of hours of service provided to the individual and his/her collaterals. PROS programs that offer Clinical Treatment as part of the service package will be reimbursed at a higher rate than programs which do not. Programs which do not provide clinical treatment will be expected to provide clinical linkages. PROS clients will be given free choice as to whether they wish to receive clinical treatment through the PROS. PROS providers will need to abide by certain program and billing restrictions if they currently operate a clinic and/or choose to offer optional clinical treatment services within the PROS.

Intensive Rehabilitation

If the client receives Intensive Rehabilitation from a comprehensive PROS, a regionally based monthly case payment will be paid in addition to the Community Rehabilitation and Support case payment. If the client attends a limited license PROS, an Intensive Rehabilitation case payment will be paid.

Ongoing Rehabilitation and Support

If the client receives Ongoing Rehabilitation and Support from a comprehensive PROS, a regionally based monthly case payment will be paid in addition to the Community Rehabilitation and Support case payment. If the client attends a limited license PROS, the Ongoing Rehabilitation and Support case payment will be paid. A program which bills for Intensive Rehabilitation cannot also bill for Ongoing Rehabilitation and Support.

TN 03-45

Approval Date JUN 03 2004

Supersedes TN Now Effective Date APR 01 2004

New York

Attachment 4.19-B

Page 3M

Assertive Community  
Treatment (ACT)

Services will be provided primarily in the community by a licensed multi-disciplinary team under the supervision of a psychiatrist which meets with the recipient or the recipient's significant others a minimum of six times per month for full ACT payment, or two times per month for ACT step-down payment. For full ACT payment, at least three of the six contacts must be with the Medicaid recipient. For ACT step-down services, both of the two required contacts must be with the client.

Monthly fees as approved by Division of the Budget will be set by dividing total gross approved costs by twelve months and the number of clients and will include a vacancy factor of 10%. OMH will consult with DOH regarding any changes to the fees.

TN 01-01 Approval Date 05/29/01  
Supersedes TN New Effective Date 01/01/01

OFFICIAL

Attachment 4.19-B  
(04/07)

**Laboratory Services**

Fee Schedule developed by Department of Health and approved by Division of the Budget. In compliance with Section 2303 of the Deficit Reduction Act of 1984, on the aggregate, Medicaid fees for clinical diagnostic laboratory tests are not to exceed those amounts recognized by Medicare.

**Home Health Services/Certified Home Health Agencies**

Prospective, cost based hourly and per visit rates for five services shall be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended or, if lower, the charge. Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April 1, 1995 through December 31, 1995, and for rate periods beginning on or after January 1, 1996 through March 31, 1999, and on July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, [2007] 2009, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. In the 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, rate periods respectively the amount of such reduction in certified home health agency rates of payments made during the twelve month period running from April 1, of the year prior to the respective rate period through March 31, of such respective rate period shall be adjusted in the respective rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31, of the applicable twelve month period to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. The amount of such reduction in certified home health agency rates of payment made during the period July 1, 1999 through March 31, 2000, shall be adjusted in the 2000 rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, 2000 and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million one hundred twenty-five thousand dollars or is less than one million one hundred twenty-five thousand dollars for payments made on or before March 31, 2000, to reflect the amount by which such savings are in excess of or lower than one million one hundred twenty-five thousand dollars.

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For the rate periods on and after January 1, 2005 through December 31, 2006, and April 1, 2007 through March 31, 2009, there shall be no such reconciliation of the amount of savings in excess of or lower than one million five hundred thousand dollars.

In addition, separate payment rates for nursing services provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS) shall be established based upon regional services prices. Such prices shall be computed based upon average nursing costs per visit calculated by aggregating base year allowable costs and statistics reported by certified home health agencies within each of four state regions, and increased by a case mix adjustment factor which represents the relative ratio of additional resources needed to provide home care nursing services to AIDS patients when compared to the average case mix of home care patients. Such AIDS regional nursing prices will be trended annually.

The Commissioner shall adjust medical assistance rates of payment for services provided by AIDS home care programs for purposes of improving recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility in the following amounts for services provided on and after December first, two thousand two.

Rates of payment by governmental agencies for AIDS home care programs (including services provided through contracts with licensed home care services agencies) shall be increased by three percent.

Providers which have their rates adjusted for this purpose shall use such funds solely for the recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility. Providers are prohibited from using such funds for any other purpose.

The Commissioner is authorized to audit each provider to ensure compliance with this purpose and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility.

In the case of services provided by providers through contracts with licensed home care services agencies, rate increases received by providers shall be reflected in either the fees paid or benefits or other supports provided to non-supervisory home care services workers or any worker with direct patient care responsibility of such contracted licensed home care services agencies and such fees, benefits or other supports shall be proportionate to the contracted

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volume of services attributable to each contracted agency. Such agencies shall submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility and shall maintain in their files expenditure plans specifying how such funds will be used for such purposes. The Commissioner is authorized to audit such agencies to ensure compliance with such certifications and expenditure plans and shall recoup any funds determined to have been used for purposes other than those set forth in this section.

The Commissioner of Health will additionally adjust rates of payment for AIDS home care service providers, for the purpose of improving recruitment and retention of home health aides or other non-supervisory personnel with direct patient care responsibility.

These additional adjustments to rates of payments shall be calculated by allocating the available funding proportionally based on each AIDS home care service provider's, home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recent cost report as submitted to the Department prior to November 1, 2005, to the total of such hours for all eligible AIDS home care service providers. The total aggregate available funding for AIDS home care service providers is as follows:

- For the period June 1, 2006 through December 31, 2006 - \$540,000.
- For the period January 1, 2007 through June 30, 2007 - \$540,000.
- For the period July 1, 2007 through March 31, 2008 - \$1,080,000.
- For the period April 1, 2008 through March 31, 2009 - \$1,080,000
- For the period April 1, 2009 through March 31, 2010 - \$1,080,000.
- For the period April 1, 2010 through March 31, 2011 - \$1,080,000.

Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation.

For providers established after November 1, 2005, the Department utilizes Medicaid data from the initial cost report submitted to the Department, which would allow the inclusion of those providers in the distribution.

Funds received through this program are to be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or other personnel with direct patient care responsibility. Each agency receiving funds shall submit, at a time and in a manner determined by the Commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory home health aides or any personnel with direct patient care responsibility. The Commissioner is authorized to audit each such agency or program to ensure compliance with this written certification and may recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home health aides or other personnel with direct patient care responsibility. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

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**Accessibility, Quality, and, Efficiency of Home Care Services**

The Commissioner of Health shall adjust rates of payment for services provided by AIDS home care service providers for the purpose of enhancing the provision, accessibility, quality, and/or efficiency of home care services. These rate adjustments shall be for the purposes of assisting such providers, located in social services districts that do not include a city with a population of over one million persons, in meeting the cost of:

- (i) Increased use of technology in the delivery of services, including clinical and administrative management information systems;
- (ii) Specialty training of direct service personnel in dementia care, pediatric care, and/or the care of other conditions or populations with complex needs;
- (iii) Increased auto and travel expenses associated with rising fuel prices, including the increased cost of providing services in remote areas;
- (iv) Providing enhanced access to care for high need populations.

The Commissioner shall increase the rates of payment for all eligible providers in an [amount up to an] aggregate amount of \$16,000,000 annually for the periods June 1, 2006 through March 31, 2007, [and] July 1, 2007 through March 31, 2008, and June 1, 2008 through March 31, 2009.

Rates will be adjusted in the form of a uniform percentage add-on as [determined] calculated by the Department, based upon the proportion of total allocated dollars, to the total Medicaid expenditures for covered home care services provided in local social services districts that do not include a city with a population over one million. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

**Criminal Background Checks for AIDS Home Care Program Providers**

Effective April 1, 2005, AIDS home care program providers must obtain a criminal history record check from the United States Attorney General for any prospective unlicensed direct care employee. This includes obtaining, as part of an application for employment, all information from a prospective employee necessary for initiating the criminal history record

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check, including, but not limited to, a finger print card of the prospective employee. The federal fee and the costs associated with obtaining the fingerprint card shall be separately identified on any report of costs submitted to the Department of Health and shall be deemed an allowable cost for Medicaid rates of payment. Reimbursement for the period April 1, 2005 through March 31, 2006 and for the period April 1, 2006 through [March 31, 2007] August 31, 2006, shall be made retrospectively based upon cost reports submitted for the 2005 and 2006 rate years, respectively. For new providers or existing providers for which cost report data is unavailable, payment will be based on budgeted costs and subsequently prospectively adjusted to reflect actual costs. Reimbursement for all types of providers shall total no more than \$5,000,000 for the April 1, 2005 through March 31, 2006 period and no more than [~~\$13,400,000~~] \$5,600,000 for the April 1, 2006 through [March 31, 2007] August 31, 2006 period. Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current rates of payment and will be determined by the percent of Medicaid utilization to total utilization for each provider. If the total cost for these criminal background checks for all types of providers exceeds the amounts set forth for the specified period, provider specific reimbursement will be reduced proportionally based on each eligible provider's reported costs for criminal background checks to the total costs of criminal background checks of all eligible providers.

Effective September 1, 2006, AIDS home care program providers shall request criminal history background checks from the Department of Health for unlicensed prospective employees who will provide direct care or supervision to patients, residents, or clients of such providers. The criminal history information consists of both a state and a national criminal history check.

AIDS home care program providers may claim as reimbursable costs under the medical assistance program, costs reflecting the fee established pursuant to law by the NYS Division of Criminal Justice Services for processing a state criminal history information check, the fee imposed by the Federal Bureau of Investigation for a national criminal history check, and the administrative costs associated with obtaining the fingerprints and completing the fingerprint cards. These costs shall be separately identified on any report of costs submitted to the Department of Health.

Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current Medicaid rate of payment based on the costs reported for the period two years prior to the rate period. The proportionate costs for criminal background checks will be allocated to Medicaid based on the percent of Medicaid utilization of services provided to the total services provided for all payers, services being defined as units of service (i.e. hours or visits). The costs allocated to Medicaid will be divided by the Medicaid units of service for the period two years prior to the rate year to constitute the rate add-on.

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### Personal Emergency Response Services

Reimbursement for Personal Emergency Response Services (PERS) will be provided under the auspices of SDSS through contractual arrangements between the LDSS and the provider. Locally negotiated rates must include the costs for renting or leasing PERS equipment, the installation, maintenance, and the removal of PERS equipment from the clients' home. A second rate must also be negotiated by the local district for a monthly monitoring service charge. These two rates must not exceed the local prevailing rate or the SDSS established cap.

For the period April 1, 1995 through March 31, 1996, the Department of Social Services in consultation with the Department of Health shall establish a state share medical assistance cost savings target for each certified home health agency, which is to be achieved as a result of the agency's development and implementation of personal emergency response services and shared aide efficiency initiatives. The aggregate of such state share targets shall not exceed fifteen million five hundred thousand dollars.

### Services Provided To Medically Fragile Children

For purposes of this section, a medically fragile child shall mean a child, up to twenty-one years of age, who is at risk of hospitalization or institutionalization for reasons that include but are not limited to the following: children who are technologically-dependent for life or health-sustaining functions; require complex medication regimen or medical interventions to maintain or improve their health status; or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk. These children are capable of being cared for at home if provided with appropriate home care services including but not limited to continuous nursing services.

For the period beginning January 1, 2007 and thereafter [through December 31, 2010], rates of payment for continuous nursing services for medically fragile children provided by a certified home health agency, or by registered nurses or licensed practical nurses who are independent providers, shall be established to ensure the availability of such services, and shall be established at a rate that is thirty percent higher than the provider's current rate for private duty nursing services. A certified home health agency that receives such rates for continuous nursing services for medically fragile children shall use such enhanced rates to increase payments to registered nurses and licensed practical nurses who provide these services. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

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**Home Telehealth Services**

Beginning on October 1, 2007, the Commissioner of Health is authorized to establish fees to reimburse the cost of home telehealth services provided by a certified home health agency, including those that provide AIDS home care services.

The Commissioner shall reimburse for telehealth services if such services are provided only in connection with federal Food and Drug Administration approved and interoperable devices, which are incorporated as part of a patient's plan of care.

The purpose of providing telehealth services shall be to assist in the effective monitoring and management of patients whose medical, functional, and/or environmental needs can be appropriately and cost-effectively met at home through the application of telehealth intervention.

Reimbursement for home telehealth services is to be provided for Medicaid patients with conditions or clinical circumstances associated with the need for frequent monitoring, and/or the need for frequent physician, skilled nursing or acute care services, and where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits or acute long term care facility admissions. Conditions or clinical circumstances shall include, but not be limited to, congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding.

Rates established by the Commissioner of Health and approved by the Director of the Budget shall reflect telehealth services costs on a daily basis to account for daily variation in the intensity and complexity of patients' telehealth service needs. Such rates shall further reflect the cost of the daily operation and provision of such services including the following functions performed by a participating certified home health agency:

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- (i) monitoring of patient vital signs;
- (ii) patient education;
- (iii) medication management;
- (iv) equipment maintenance; and
- (v) review of patient trends and/or other changes in patient condition necessitating professional intervention.

Daily rates for home telehealth services provided to Medicaid patients shall not exceed \$9.65 per day per patient for clients with a class 2 device capable of interoperability and \$11.08 per client per day for clients with a device connected to a home care point of care system. A one time installation fee of \$50 shall also be payable for devices installed in client homes on and after October 1, 2007.

All providers will be required to disallow any cost (nursing or equipment) related to the provision of the telehealth service from the base year cost utilized to determine rates for other cost based CHHA services such as nursing and home health aide.

Effective for services on or after October 1, 2007, the following uniform fees will be paid by governmental and non-governmental providers:

- Installation \$50 per installation
- Daily Monitoring – Type 1 \$8.88 per day
- Daily Monitoring – Type 2 \$10.19 per day

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The Department of Health shall calculate an adjustment to the approved rate of payment for the period July 1, 1995 to December 31, 1995, for each such agency by an amount sufficient to achieve its agency-specific savings target, as established by the Department of Social Services, prior to March 31, 1996. Such adjustment shall not be considered a rate change or rate adjustment, but shall serve as an off set of payments to the agency against its liability to the state for savings to be achieved under its agency-specific target, as established by the Department of Social Services.

On or before January 1, 1996, the Department of Social Services shall notify agencies of the progress made toward reaching the specific targets, including information on the number of new clients being served, the types of services provided, and the amount of any state funds which have been offset from their rates and applied to the agency target. Any agency that believes that the offset of its payments was incorrect may request the Commissioner of the Department of Social Services to review its payments by filing a written request for review with such Commissioner within ten days of receipt of such notice. If, after reviewing the determination, the Commissioner of the Department of Social Services finds that the payments were incorrect, such Commissioner shall determine the amount of the payments to be restored, if any, and authorize the payment of any amount incorrectly offset, as soon as possible, but in no event later than June 30, 1996.

As soon as practicable after March 31, 1996, the Commissioner of Social Services shall review the total payments made to each such agency; the amount of the offset from payments otherwise due the agency; and the total savings actually achieved by the agency as a result of the agency's development and implementation of personal emergency response systems and shared aide efficiencies initiatives. If the Commissioner of Social Services determines that payments to any agency were offset in an amount greater than was necessary to meet its agency-specific savings target given the agency's actual savings achieved, the Commissioner of Social Services shall authorize payment of such amount to such agency, as soon as possible, but in no event later than June 30, 1996. Any agency dissatisfied with the determination of the Commissioner of Social Services may request the Commissioner of Social Services to review its payments, offsets and savings achieved by filing a written request for review with such Commissioner within ten days of receipt of such notice. If, after reviewing the determination, such Commissioner finds that the determination was incorrect, such Commissioner shall determine the amount of the payments to be restored, if any, and authorize the payment of any amount incorrectly offset, as soon as possible, but in no event later than September 30, 1996.

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Effective for the period August 1, 1996 through November 30, [2007] 2009, certified home health agencies (CHHAs) shall be required to increase their Medicare revenues relative to their Medicaid revenues measured from a base period (calendar year 1995) to a target period (the 1996 target period is August 1, 1996 through March 31, 1997, the 1997 target period is January 1, 1997 through November 30, 1997, the 1998 target period shall mean January 1, 1998 through November 30, 1998, the 1999 target period shall mean January 1, 1999 through November 30, 1999, the 2000 target period shall mean January 1, 2000 through November 30, 2000, the 2001 target period shall mean January 1, 2001 through November 30, 2001, the 2002 target period shall mean January 1, 2002 through November 30, 2002, the 2003 target period shall mean January 1, 2003 through November 30, 2003, the 2004 target period shall mean January 1, 2004 through November 30, 2004, the 2005 target period shall mean January 1, 2005 through November 30, 2005, the 2006 target period shall mean January 1, 2006 through November 30, 2006, [and] the 2007 target period shall mean January 1, 2007 through November 30, 2007, the 2008 target period shall mean January 1, 2008 through November 30, 2008, and the 2009 target period shall mean January 1, 2009 through November 30, 2009, or receive a reduction in their Medicaid payments. For this purpose, regions shall consist of a downstate region comprised of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region comprised of all other New York State counties. A certified home health agency shall be located in the same county utilized by the Commissioner of Health for the establishment of rates pursuant to Article 36 of the Public Health Law. Regional group shall mean all those CHHAs located within a region. Medicaid revenue percentage shall mean CHHA revenues attributable to services provided to persons eligible for payments pursuant to Title 11 of Article 5 of the Social Services law divided by such revenues plus CHHA revenues attributable to services provided to beneficiaries of Title XVIII of the Federal Social Security Act (Medicare).

Prior to February 1, 1997, for each regional group, 1996 Medicaid revenue percentage for the period commencing August 1, 1996, to the last date for which such data is available and reasonably accurate shall be calculated. Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, [and] prior to February 1, 2006, prior to February 1, 2007, prior to February 1, 2008, and prior to February 1, 2009 for each regional group, the Commissioner of Health shall calculate the prior years Medicaid revenue percentages for the period beginning January 1 through November 30 of such prior year. By September 15, 1996, for each regional group, the base period Medicaid revenue percentage shall be calculated.

For each regional group, the 1996 target Medicaid revenue percentage shall be calculated by subtracting the 1996 Medicaid revenue reduction percentages from the base period Medicaid revenue percentages. The 1996 Medicaid revenue reduction percentage, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups shall be equal to:

- one and one-tenth percentage points for CHHAs located within the downstate region; and[,]
- six-tenths of one percentage point for CHHAs located within the upstate region.

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For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, for each regional group, the target Medicaid revenue percentage for the respective year shall be calculated by subtracting the respective year's Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The Medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups shall be equal to:

- one and one-tenth percentage points for CHHAs located within the downstate region; and[,]
- six-tenths of one percentage point for CHHAs located within the upstate region.

For each regional group, the 1999 target Medicaid revenue percentage shall be calculated by subtracting the 1999 Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The 1999 Medicaid revenue reduction percentages, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups shall be equal to:

- eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region; and
- forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;

For each regional group, if the 1996 Medicaid revenue percentage is not equal to or less than the 1996 target Medicaid revenue percentage, a 1996 reduction factor shall be calculated by comparing the 1996 Medicaid revenue percentage to the 1996 target Medicaid revenue percentage to determine the amount of the shortfall and dividing such shortfall by the 1996 Medicaid revenue reduction percentage. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the 1996 Medicaid revenue percentage is equal to or less than 1996 target Medicaid revenue percentage, the 1996 reduction factor shall be zero. For each regional group, the 1996 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount.

- two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region; and
- seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region.

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For each regional group reduction, if the 1996 reduction factor shall be zero, there shall be no 1996 state share reduction amount.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, for each regional group, if the Medicaid revenue percentage for the respective year is not equal to or less than the target Medicaid revenue percentage for such respective year, the Commissioner of Health shall compare such respective year's Medicaid revenue percentage to such respective year's target Medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's Medicaid revenue reduction percentage, shall be called the reduction factor for such respective year. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the Medicaid revenue percentage for a particular year is equal to or less than the target Medicaid revenue percentage for that year, the reduction factor for that year shall be zero.

For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, for each regional group, the reduction factor for the respective year shall be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year.

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- two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region; and
- seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region;

For each regional group reduction, if the reduction factor for a particular year is zero, there shall be no state share reduction amount for such year.

For each regional group, the 1999 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1999 state share reduction amount:

- one million seven hundred ninety-two thousand five hundred dollars (\$1,792,500) for CHHAs located within the downstate region; and
- five hundred sixty-two thousand five hundred dollars (\$562,500) for CHHAs located within the upstate region;

For each regional group reduction, if the 1999 reduction factor is zero, there shall be no 1999 state share reduction amount.

For each regional group, the 1996 state share reduction amount shall be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage within the applicable regional group. This proportion shall be multiplied by the applicable 1996 state share reduction amount. This amount shall be called the 1996 provider specific state share reduction amount.

The 1996 provider specific state share reduction amount shall be due to the state from each CHHA and may be recouped by the State by March 31, 1997, in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, for each regional group, the state share reduction amount for the respective year shall be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year within the applicable regional group. This proportion shall be multiplied by the applicable year's state share reduction amount for the applicable regional group. This amount shall be called the provider specific state share reduction amount for the applicable year.

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The provider specific state share reduction amount for 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, respectively, shall be due to the state from each CHHA and the amount due for each respective year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

CHHAs shall submit such data and information at such times as the Commissioner of Health may require. The Commissioner of Health may use data available from third party payors.

On or about June 1, 1997, for each regional group, the Commissioner of Health shall calculate for the period of August 1, 1996 through March 31, 1997, a Medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided herein for calculating such amounts for the 1996 target period. The provider specific state share reduction amount calculated shall be compared to the 1996 provider specific state share reduction amount. Any amount in excess of the 1996 provider specific state share reduction amount shall be due to the state from each CHHA and may be recouped. If the amount is less than the 1996 provider specific state share reduction amount, the difference shall be refunded to the CHHA by the state no later than July 15, 1997. CHHAs shall submit data for the period August 1, 1996 through March 31, 1997, to the Commissioner of Health by April 15, 1997.

If a CHHA fails to submit data and information as required, such CHHA shall be presumed to have no decrease in Medicaid revenue percentage between the base period and the applicable target period for purposes of the calculations described herein and the Commissioner of Health shall reduce the current rate paid to such CHHA by state governmental agencies pursuant to Article 36 of the Public Health Law by one percent for the period beginning on the first day of the calendar month following the applicable due date as established by the Commissioner of Health and continuing until the last day of the calendar month in which the required data and information are submitted.

Notwithstanding any inconsistent provision set forth herein, the annual percentage reductions as set forth above, shall be prorated by the Commissioner of Health for the period April 1, [2006] 2007 through March 31, [2007] 2009.

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**Certified Home Health Care Agency - Insurance Costs**

The Commissioner of Health is authorized to provide for increased payments to certified home health agencies to support increased employee fringe benefit costs associated with the agencies' provision of enhanced health care coverage for their employees.

The cost of such health care related increased employee fringe benefits is a reimbursable cost for eligible certified home health agencies. Eligible home care agencies [, as determined by the Commissioner of Health,] are those agencies whose workers are employed in cities within the state which have populations in excess of one million persons [and] or counties within the state which have populations in excess of [one million persons] nine hundred thousand persons if the county is located within the metropolitan commuter transportation district and meet the following conditions: (a) at least fifty percent of the [persons receiving services from] actual total hours of service for the period July 1, 2007 through March 31, 2008 provided by such employers are provided to recipients of medical assistance; and (b) the employer contributes to a group health insurance plan or employer based group health plan on behalf of such employees; and (c) no benefits are provided under the group health insurance plan or employer based group health plan in excess of the benefits provided to the majority of hospital workers in the community in which the home health care workers are employed].

[Total] Medicaid payments to eligible home care agencies are based on total funds available for this program, allocated proportionately by Medicaid hours of service provided by each eligible provider. [the documented approved costs of the eligible agency for group health insurance premiums paid for their employed home care attendants and allocable to the Medicaid hours of service provided by such employees.] Payments may, in the aggregate, and on an annual basis, be no more than \$58,000,000 provided however, that for the period October 2 through December 31, 2003, the amount will increase by \$105,000,000; and for annual periods [on and after] January 1, 2004 through June 30, 2007, the amount of funding shall be no more than \$163,000,000 in the aggregate. For the period July 1, 2007 through March 31, 2008, the amount of funding shall be \$122,300,000 in the aggregate for all eligible certified home health agencies and personal care providers. Rates of payment shall be adjusted for eligible providers and allocated proportionally [to reflect the Medicaid share of the approved costs] based on the [proportional] relationship of the provider's Medicaid annual hours of service [care rendered to Medicaid beneficiaries] to the total Medicaid annual hours of service [care] rendered [to] by all of the providers [patients]

TN #07-32

Approval Date APR 08 2008

Supersedes TN 05-49

Effective Date JUL 01 2007

**OFFICIAL**

**New York  
4 (a)(vi)(A)**

**Attachment 4,19-B  
(07/07)**

based upon each provider's actual Medicaid hours of service for which payment has been made by the State's Medicaid Management Information System for the period July 1, 2007 through March 31, 2008.

Eligible providers shall use such funds solely for the purpose of supporting health insurance coverage for their employees and are prohibited from using such funds for any other purpose. The Commissioner is authorized to audit such providers for the purpose of ensuring compliance and shall recoup any funds determined to have been used for purposes other than those authorized.

[The Commissioner may modify the amounts made available for any specific annual period so long as the total amount made available for the period is not exceeded.] The effective period is January 1, 2000 through [June 30, 2007] March 31, 2008.

TN #07-32 \_\_\_\_\_

Approval Date APR 0 8 2008

Supersedes TN New

Effective Date JUL 0 1 2007

**New**

**New York  
4 (a)(vii)**

**Attachment 4.19-B  
(10/03)**

The Commissioner of Health is authorized to require group health insurance plans and employer based group health plans to report to the Department, insofar as such reporting does not violate any provisions the Federal Employee Retirement Income Security Act (ERISA), at such times and in such manner as the Commissioner shall decide, any information needed [to operate such a demonstration project], including but not limited to, the number of people in such plans who become ineligible each month for the continuation coverage described herein. In addition, every certified health maintenance organization and every insurer licensed by the Superintendent of Insurance shall submit reports in such form and at such times as may be required [to implement this demonstration].

**Recruitment And Retention**

The Commissioner shall adjust medical assistance rates of payment for services provided by certified home health agencies for purposes of improving recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility in the following amounts for services provided on and after December 1, 2002.

Rates of payment by governmental agencies for certified home health agency services (including services provided through contracts with licensed home care services agencies) shall be increased by three percent.

Providers, which have their rates adjusted for this purpose shall use such funds solely for the recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility. Providers are prohibited from using such funds for any other purpose.

The Commissioner is authorized to audit each provider to ensure compliance with this purpose and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility.

In the case of services provided by providers through contracts with licensed home care services agencies, rate increases received by providers shall be reflected in either the fees paid or benefits or other supports provided to non-supervisory home care services workers or any worker with direct patient care responsibility of such contracted licensed home care services agencies and such fees, benefits or other supports shall be proportionate to the contracted volume of services attributable to each contracted agency. Such agencies shall submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility and shall maintain in their files expenditure plans specifying how such funds will be used for such purposes. The Commissioner is authorized to audit such agencies to ensure compliance with such certifications and expenditure plans and shall recoup any funds determined to have been used for purposes other than those set forth in this section.

TN #05-49 \_\_\_\_\_

Approval Date NOV 21 2006

Supersedes TN 03-57

Effective Date JUL - 1 2005

**OFFICIAL**

### Criminal Background Checks for Certified Home Health Agencies

Effective April 1, 2005, certified home health agencies must obtain a criminal history record check from the United States Attorney General for any prospective unlicensed direct care employee. This includes obtaining, as part of an application for employment, all information from a prospective employee necessary for initiating the criminal history record check, including, but not limited to, a finger print card of the prospective employee. The federal fee and the costs associated with obtaining the fingerprint card shall be separately identified on any report of costs submitted to the Department of Health and shall be deemed an allowable cost for Medicaid rates of payment. Reimbursement for the period April 1, 2005 through March 31, 2006 and for the period April 1, 2006 through [March 31, 2007] August 31, 2006, shall be made retrospectively based upon cost reports submitted for the 2005 and 2006 rate years, respectively. For new providers or existing providers for which cost report data is unavailable, payment will be based on budgeted costs and subsequently adjusted to reflect actual costs. Reimbursement for all types of providers shall total no more than \$5,000,000 for the April 1, 2005 through March 31, 2006 period and no more than [~~\$13,400,000~~] \$5,600,000 for the April 1, 2006 through [March 31, 2007] August 31, 2006 period. Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current rates of payment and will be determined by the percent of Medicaid utilization to total utilization for each provider. If the total cost for these criminal background checks for all types of providers exceeds the amounts set forth for the specified period, provider specific reimbursement will be reduced proportionally based on each eligible provider's reported costs for criminal background checks to the total costs of criminal background checks of all eligible providers.

Effective September 1, 2006, certified home health agencies shall request criminal history background checks from the Department of Health for unlicensed prospective employees who will provide direct care or supervision to patients, residents, or clients of such providers. The criminal history information consists of both a state and a national criminal history check.

Certified home health care agencies may claim as reimbursable costs under the medical assistance program, costs reflecting the fee established pursuant of law by the NYS Division of Criminal Justice Services for processing a state criminal history information check, the fee imposed by the Federal Bureau of Investigation for a national criminal history check, and the administrative costs associated with obtaining the fingerprints and completing the fingerprint cards. These costs shall be separately identified on any report of costs submitted to the Department of Health.

Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current Medicaid rate of payment based on the costs reported for the period two years prior to the rate period. The proportionate costs for criminal background checks will be allocated to Medicaid based on the percent of Medicaid utilization of services provided to the total services provided for all payers, services being defined as units of service (i.e. hours or visits). The costs allocated to Medicaid will be divided by the Medicaid units of service for the period two years prior to the rate year to constitute the rate add-on.

TN #06-70 \_\_\_\_\_

Approval Date JUN 18 2007

Supersedes TN #06-<sup>53</sup>~~33~~ \_\_\_\_\_

Effective Date SEP 01 2006

**OFFICIAL**

**New York  
4(a)(viii)(1)**

**Attachment 4.19-B  
(04/08)**

**Recruitment and Retention of Direct Patient Care Personnel**

The Commissioner of Health will additionally adjust rates of payment for certified home health agencies, for purposes of improving recruitment and retention of home health aides or other non-supervisory personnel with direct patient care responsibility.

These additional adjustments to rates of payments shall be calculated by allocating the available funding proportionally based on each certified home health agency's, home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's cost report as submitted to the Department prior to November 1, 2005 to the total of such hours for all certified home health agency providers. The total aggregate available funding for all eligible certified home health agency providers is as follows:

- For the period June 1, 2006 through December 31, 2006 - \$20,100,000.
- For the period January 1, 2007 through June 30, 2007 - \$20,100,000.
- For the period July 1, 2007 through March 31, 2008 - \$40,200,000.
- For the period April 1, 2008 through March 31, 2009 - \$40,200,000.
- For the period April 1, 2009 through March 31, 2010 - \$40,200,000.
- For the period April 1, 2010 through March 31, 2011 - \$40,200,000.

For providers established after November 1, 2005, the Department utilizes Medicaid data from the initial cost report submitted to the Department, which would allow the inclusion of those providers in the distribution.

TN #08-31 \_\_\_\_\_

Approval Date APR 09 2009

Supersedes TN New

Effective Date APR 01 2006

Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation.

Funds received through this program are to be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or other personnel with direct patient care responsibility. Each agency receiving funds shall submit, at a time and in a manner determined by the Commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory home health aides or any personnel with direct patient care responsibility. The Commissioner is authorized to audit each such agency or program to ensure compliance with this written certification and may recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home health aides or other personnel with direct patient care responsibility. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

**Accessibility, Quality, and, Efficiency of Home Care Services**

The Commissioner of Health shall adjust rates of payment for services provided by certified home health agencies for the purpose of enhancing the provision, accessibility, quality, and/or efficiency of home care services. These rate adjustments shall be for the purposes of assisting such providers, located in social services districts that do not include a city with a population of over one million persons, in meeting the cost of:

- (i) Increased use of technology in the delivery of services, including clinical and administrative management information systems;
- (ii) Specialty training of direct service personnel in dementia care, pediatric care, and/or the care of other conditions or populations with complex needs;
- (iii) Increased auto and travel expenses associated with rising fuel prices, including the increased cost of providing services in remote areas;

TN #08-31 \_\_\_\_\_

Approval Date APR 09 2009

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Effective Date APR 01 2008

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(iv) Providing enhanced access to care for high need populations.

The Commissioner shall increase the rates of payment for all eligible providers in an [amount up to an] aggregate amount of \$16,000,000 annually for the periods June 1, 2006 through March 31, 2007, [and] July 1, 2007 through March 31, 2008, and June 1, 2008 through March 31, 2009.

Rates will be adjusted in the form of a uniform percentage add-on as [determined] calculated by the Department, based upon the proportion of total allocated dollars, to the total Medicaid expenditures for covered home care services provided in local social services districts that do not include a city with a population over one million. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

TN #08-33 \_\_\_\_\_

Approval Date MAR 20 2009

Supersedes TN #07-13 \_\_\_\_\_

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New York  
4 (b)

Attachment 4.19B  
SPA 95-25

Home Health Services  
Community and Residential Based  
Certified Home Health Agencies  
Under Article 36 of the Public  
Health Law

An allowance will be established annually and added to Medicaid rates of payment for certified agencies which can demonstrate a financial shortfall as a result of providing services to a disproportionate share of uninsured low-income patients. Losses will be calculated by applying the current Medicaid payment rate to base year units of service to uninsured low-income patients, offset by related out-of-pocket patient receipts, subsidy grants and State aid deficit financing to publically-sponsored facilities. An annual agency loss coverage will be established by applying calculated losses to a nominal loss coverage ratio scale within the limits of pool allocations to public and non-public agencies.

~~[For purposes of establishing rates of payment by governmental agencies for certified home health agencies for rate the periods beginning on or]~~

TN 95-25 Approval Date FEB 11 1999  
Supersedes TN 92-25 Effective Date APR 1 1995

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SPA 95-25

~~[after January first, nineteen hundred ninety five, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as a base year in determining rates of payment, shall not exceed thirty percent of total reimbursable base year operational costs of such provider of services.]~~

TN 95-25 Approval Date FEB 11 1999  
Supersedes TN 93-25 Effective Date APR 1 1995

TYPE OF SERVICE

Assisted Living Programs

METHOD OF REIMBURSEMENT

In accordance with Public Health law Section 3614(6) and 10 NYCRR Subpart 86-7, the Commissioner of Health and subject to approval for the State Director of the Budget, establishes per diem payment rates that are payment-in-full for the Title XIX Personal Care Services that the Assisted Living Program provides directly or through contracts with a Long Term Home Health Care Program, a certified home health agency or other qualified providers; nursing services, home health aid services, physical therapy, occupational therapy, speech equipment not requiring prior approval, personal emergency response services, and adult day health care provided in a program approved by the Commissioner of Health. Payment rates are established for 1992 for each of sixteen patient classification groups in each of sixteen regions, and the 1992 payment rates are increased by a roll factor for each subsequent year. The payment rates are related to fifty percent of the amounts which otherwise would have been expended to provide the appropriate level of care in a residential health care facility in the applicable regions and consist of a direct component and other than direct component. For 1992, the direct and other than direct components for each patient classification group in each of sixteen regions are summed and multiplied by fifty percent. For subsequent calendar years, the 1992 payment rates are increased by the applicable roll factor. Payment rates cannot exceed prevailing charges in the locality.

TR No. 97-10Supersedes 94-11

TR No. \_\_\_\_\_

Approval Date: JUL 08 1997Effective Date OCT 01 1996

Type of Service

Prescribed Drugs

Method of Reimbursement

Reimbursement is the lower of: 1) the upper limit if established by the Federal Government for specific multiple source drugs, plus a dispensing fee, or 2) the billing pharmacy's usual and customary price charged to the general public, or 3) the state maximum acquisition cost (SMAC) plus dispensing fee, or 4) the Estimated Acquisition Cost (EAC) established by State Department of Health, plus dispensing fee. (a) For sole or multi-source brand name drugs, the EAC is defined as average wholesale price (AWP) less sixteen and twenty-five one hundredths percent. (b) For multi-source generic drugs, the EAC is defined as the lower of AWP less twenty-five percent. (c) For specialized HIV pharmacies, the EAC is defined as AWP of the drug less twelve percent. The dispensing fee for generic prescription drugs will be \$4.50 per prescription and for brand name prescription drugs will be \$3.50. However, for brand name prescription drugs, when the net cost of the brand name drug, after consideration of all rebates is less than the cost of the generic equivalent, the dispensing fee shall be \$4.50 per prescription. The State Department of Health's prescription drug pricing service will determine whether a prescription drug is generic or brand name.

A SMAC may be established for any drug, including brand name multi-source drugs, for which two or more A-rated therapeutically equivalent, multi-source drugs where a significant cost difference exists. The drugs used for the SMAC price calculation formula will be active (non-obsolete) drugs eligible for rebates under the Federal Medicaid Drug Rebate Program authorized by Section 1927 of the Social Security Act and which are available in sufficient quantities in the marketplace. The source of comparable drug prices will be nationally recognized comprehensive data files maintained by a vendor under contract with the State. While the final SMAC pricing methodology is proprietary, multiple drug pricing resources are utilized to determine the preliminary acquisition cost for generic drugs. These resources include pharmacy providers, wholesalers, drug file vendors such as First Data Bank, and pharmaceutical manufacturers. The preliminary acquisition cost for each product is maintained in a SMAC pricing file database. Products are then sorted into drug groups by GSN (Generic Code Number Sequence Number) which denotes the same generic name, strength, and dosage form. The vendor will apply the proprietary formula to the estimated acquisition costs in each GSN giving due consideration to the lower cost products. Multipliers are used to increase the applicable lowest price by a percentage. The resulting price becomes the SMAC price which is then applied to all drug products in that specific GSN. The SMAC file is updated monthly. New York's SMAC list is available from a vendor under contract with the Department.

TN 09-52  
Supersedes TN 08-09

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Effective Date OCT 01 2009

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Compound Drugs: Reimbursement is determined by the State Department of Health at the cost of ingredients plus a dispensing fee of \$3.50 with an additional amount of \$0.75 as the compounding fee.

Exception: Physician Override: Reimbursement for those brand name drugs for which there are generic equivalent drugs for which reimbursement is not to exceed the aggregate of the specified upper limit for the particular drug established by the Centers for Medicare and Medicaid Services, plus a dispensing fee, will be paid at the lower of the estimated acquisition cost, plus a dispensing fee, or at the provider's usual and customary price charged to the general public when the prescriber has obtained a prior authorization when required for the brand-name drug, indicated that the brand name drug is required by placing "daw" (dispense as written) in the box located on prescription form and by writing "brand necessary" or "brand medically necessary" in his/her own handwriting on the face of the prescription.

Where it has been determined that reimbursement plus a dispensing fee does not exceed the aggregate for all drugs under the Federal Upper Limit (FUL) program, the writing by the prescriber of "brand necessary" or "brand medically necessary" will not be required. Prior authorization will not be required for these select drugs:

Indian Health Clinics and tribal clinics which have licensed pharmacies, may submit fee-for-service claims for pharmacy services provided to Native Americans and will be reimbursed at the net acquisition cost for those drugs purchased through the Federal Supply Schedule or at an amount determined by the reimbursement methodology indicated above for all other purchased drugs.

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MAR 12 2010

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08-09

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OCT 01 2009

OFFICIAL

An e-prescription financial incentive will be paid to retail pharmacies for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the-counter medications prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at the cost of ingredients plus a dispensing fee which includes 20 cents per electronic prescription/fiscal order dispensed.

TN #9-53 Approval Date APR 08 2010  
Supersedes TN NEW Effective Date NOV 15 2009

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Type of Service

Method of Reimbursement

Pharmacy Medication Therapy

Fee schedule developed by the Department of Health and approved by the Division of Budget. Except as otherwise noted in the plan, state developed fee schedules are the same for both governmental and private providers of medication therapy management services. The fee schedule and any annual/periodic adjustments to the fee schedule are published in the official New York State pharmacy provider manual available and is also available at [http://nyhealth.gov/health\\_care/medicaid/program/mtm/index.htm](http://nyhealth.gov/health_care/medicaid/program/mtm/index.htm). The agency's fee schedule was set as of December 29, 2008 and is effective for services provided on or after January 6, 2010.

TN # 09-08

Approval Date

DEC 16 2009

Supersedes TN #

new

Effective Date

JUN 11 2009

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Type of Service

Method of Reimbursement

Pharmacists as Immunizers

Fee schedule developed by the Department of Health and approved by the Division of Budget. State developed fee schedules are the same as the fee schedule established for Physicians. Pharmacies participating in the New York State Medicaid program are reimbursed a vaccine administration fee established at the same rate paid to physicians. The reimbursement to the pharmacy is on behalf of the employed pharmacist, who as the licensed practitioner is the vaccine administrator. Except as otherwise noted in the plan, state developed fee schedules are the same for both governmental and private providers. The fee schedule and any annual/periodic adjustments to the fee schedule are published in the official New York State pharmacy provider manual. The agency's fee schedule is effective for services provided on or after October 15, 2009.

TN # 09-63

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NEW

**NEW**

Effective Date

NOV 05 2009

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(04/06)**Nonprescription Drugs**

Reimbursement is the lowest of:

- (1) the usual and customary price charged to the general public;
- (2) the price established by the Commissioner of Health as shown on the NYS List of Medicaid Reimbursable Drugs for that generic category and strength in the package size nearest to that ordered; and,
- (3) Acquisition cost plus dispensing fee.

**Private Duty Nursing**

Fees determined by local districts and reviewed by the Department of Social Services.

The Commissioner of Health shall adjust rates of payment for services provided by private duty nursing providers for the purpose of enhancing the provision, accessibility, quality, and/or efficiency of home care services. These rate adjustments shall be for the purposes of assisting such providers, located in social services districts that do not include a city with a population of over one million persons, in meeting the cost of:

- (i) Increased use of technology in the delivery of services, including clinical and administrative management information systems;
- (ii) Specialty training of direct service personnel in dementia care, pediatric care, and/or the care of other conditions or populations with complex needs;
- (iii) Increased auto and travel expenses associated with rising fuel prices, including the increased cost of providing services in remote areas;
- (iv) Providing enhanced access to care for high need populations.

TN #06-53 \_\_\_\_\_

Approval Date APR 02 2007

Supersedes TN #99-01 \_\_\_\_\_

Effective Date JUN 01 2006

**OFFICIAL**

The Commissioner shall increase the rates of payment for all eligible providers in an amount up to an aggregate of \$16,000,000 annually for the periods June 1, 2006 through March 31, 2007, April 1, 2007 through March 31, 2008, and April 1, 2008 through March 31, 2009.

Rates will be adjusted in the form of a uniform percentage add-on as calculated by the Department, based upon the proportion of total allocated dollars, to the total Medicaid expenditures for covered home care services provided in local social services districts that do not include a city with a population over one million. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

**Services Provided to Medically Fragile Children**

For purposes of this section, a medically fragile child shall mean a child, up to twenty-one years of age, who is at risk of hospitalization or institutionalization for reasons that include but are not limited to the following: children who are technologically-dependent for life or health-sustaining functions; require complex medication regimen or medical interventions to maintain or improve their health status; or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk. These children are capable of being cared for at home if provided with appropriate home care services including but not limited to continuous nursing services.

For the period January 1, 2007 through December 31, [2008] 2010, rates of payment for continuous nursing services for medically fragile children shall be established to ensure the availability of such services or programs, and shall be established at a rate that is thirty percent higher than the provider's current rate for private duty nursing services. Providers that receive such rates for continuous nursing services for medically fragile children must use these enhanced rates to increase payments to registered nurses or licensed practical nurses who provide these services to medically fragile children. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

**Nursing Services (Limited)**

The Commissioner of Health, subject to the approval of the Director of the Budget, establishes reimbursement rates for certain nursing services provided to eligible residents by a certified operator of an adult home or enriched housing program that has been issued a limited license by the Department. A limited license may be issued to the certified operator of an adult home or enriched housing program and allows such operator to directly provide certain

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(01/07)**

personal care and nursing services to residents of the adult home or enriched housing program governed by the terms of the limited license. The nursing services for which reimbursement shall be provided are: the administration of subcutaneous and/or intramuscular injections and application of sterile dressings by a registered professional nurse, including associated nursing tasks, provided however, that the services provided are not services that must otherwise be provided to residents of adult homes or enriched housing programs. Regional quarter hour rates are established utilizing average fees established for private duty nursing services for the respective regions.

**Physical Therapy**

Fee schedule developed by Department of Health and approved by Division of the Budget.

**Occupational Therapy**

Fee schedule developed by Department of Health and approved by Division of the Budget.

TN #07-01

Approval Date JUN 25 2007

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**Eyeglasses and Other Visual Services**

Fee schedule developed by Department of Health and approved by Division of the Budget.

**Hearing Aid Supplies and Services**

Fee schedule developed by Department of Health and approved by Division of the Budget.

**Prosthetic and Orthotic Appliances**

Payments are limited to the lower of the usual and customary charge to the general public or fee schedule developed by Department of Health and approved by the Division of the Budget.

**Comprehensive Psychiatric Emergency Programs**

Flat fee developed by OMH and approved by the Division of the Budget.

TN #06-53

Approval Date APR 02 2007

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Effective Date JUN 01 2006

**TYPE OF SERVICE**

**METHOD OF REIMBURSEMENT**

Durable Medical Equipment

Purchase: Reimbursement must not exceed the lower of a) the maximum reimbursable amount as shown in the fee schedule for durable medical equipment; the maximum reimbursable amount will be determined for each item of durable medical equipment based on an average cost of products representative of that item; or b) the usual and customary price charged to the general public for same or similar products.

When there is no price listed in the fee schedule for durable medical equipment, payment for purchase of durable medical equipment must not exceed the lower of a) acquisition cost as established by invoice detailing the line item cost to the provider from a manufacturer or wholesaler net any rebates, discounts or valuable consideration, mailing, shipping, handling, insurance, or sales tax plus fifty percent; or b) the usual and customary price charged to the general public for the same or similar products.

When the primary payor is Medicare, payment for the purchase of durable medical equipment shall be the amount approved by Title XVIII of the Medicare Program.

Rental: monthly rental charges are determined by the Department of Health.

Medical/Surgical Supplies

Purchase: reimbursement is determined by the Department of Health at the lower of the maximum reimbursable amount; or at the usual and customary price charged to the general public.

Pharmaceutical Formula

Purchase: reimbursement is the lower of the cost to the provider plus 50% or the usual and customary price charged to the general public.

Transportation

[Fees determined by local social services districts and approved by the Division of the Budget and shall not exceed the current local prevailing charge or locally negotiated fee, whichever is lower, with the following exception:

For those clients for whom the State retains fiscal and administrative responsibility, fees are determined by the DOH Office of Financial Management using the local social services district fee for a comparable service as the upper limit of payment.]

In a fee-for-service arrangement, fees will be established by the local social services districts and subsequently approved by the Office of Health Insurance Programs. Fees will be reviewed to ensure they do not exceed the current usual and customary amount charged to the general public. However, there will be extenuating and unique circumstances where a higher fee is necessary to assure safe and appropriate transportation to necessary medical services. In those circumstances, a fee will be negotiated.

TN#: 06-52

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**Out-of-State Services**

**Fee-based providers:**

Those providers who meet their state's licensure/certification requirements are reimbursed charges up to the appropriate New York State fee, for services rendered.

**HMO's and Prepaid Health Plans**

Monthly capitation rates established through negotiation with the Department of Health and approved by the Division of the Budget are in compliance with 42 CFR Part 434, Part 442.302 and Part 447.361 including all federal requirements for the reimbursement methodology.

**Personal Care Services**

For personal care services provided pursuant to a contract between a social services district and a voluntary, proprietary or public personal care services provider, payment is made at the lower of the provider's charge to the general public for personal care services or a rate the Department establishes for the provider, subject to the approval of the Director of the Budget, in accordance with a cost-based methodology. Under the cost-based methodology, the Department determines a provider's rate based upon the provider's reported allowable costs, as adjusted by annual trend factors. The provider's rate includes payment for the provider's reported allowable trended costs only in an amount that does not exceed the ceilings for allowable costs that the Department has established for all providers in the applicable geographic group to which the provider belongs. The rate includes an adjustment for profit, for proprietary providers, or surplus, for voluntary providers.

Such rates of payment shall be further adjusted to reflect costs associated with the recruitment and retention of non-supervisory workers. For programs providing services in local social service districts which include a city with a population of over one million persons, rates shall be adjusted in accordance with a memorandum of understanding between the State of New York and the local social service districts. For programs providing services in local social services districts which do not include a city with a population of over one million persons, adjustments to Medicaid rates of payment will be calculated by allocating the total dollars available for the applicable rate period to each individual provider proportionally based on each personal care service provider's total annual hours of personal care service provided [as reported in the provider's 1999 cost report submitted to the Department of Health prior to November 1, 2001] to recipients of medical assistance to the total annual hours for all providers in this category. The allocated dollars will be included as a reimbursable cost add-on to the Medicaid rates of payment based on the Medicaid utilization data reported in each provider's annual cost report for the period two year's prior to the rate year.

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(07/07)

Adjustments to Medicaid rates of payment will, in aggregate, not exceed the following amounts for the following periods.

For programs providing services in local social service districts which include a city with a population of more than one million persons:

For the period April 1, 2002 through December 31, 2002, one hundred ten million dollars.  
For the period January 1, 2003 through December 31, 2003, one hundred eighty five million dollars.  
For the period January 1, 2004 through December 31, 2004, two hundred sixty million dollars.  
For the period January 1, 2005 through December 31, 2006, three hundred forty million dollars annually.  
For the period January 1, 2007 through [June 30,] December 31, 2007, [one hundred seventy] three hundred forty million dollars.  
For the period January 1, 2008 through March 31, 2008, eighty-five million dollars.

For programs providing services in local social service districts which do not include a city with a population of over one million persons:

For the period April 1, 2002 through December 31, 2002, seven million dollars.  
For the period January 1, 2003 through December 31, 2003, fourteen million dollars.  
For the period January 1, 2004 through December 31, 2004, twenty-one million dollars.  
For the period January 1, 2005 through December 31, 2006, twenty-seven million dollars annually; for the period August 17, 2006 through December 31, 2006, an additional aggregate amount of four million dollars.  
For the period January 1, 2007 through June 30, 2007, thirteen million five hundred thousand dollars.  
For the period July 1, 2007 through March 31, 2008, twenty-six million two hundred fifty thousand dollars.

Revisions to rates made for such recruitment and retention costs shall not be subject to subsequent adjustment or reconciliation.

The final rate is payment-in-full for all personal care services provided during the applicable rate year, subject to any revisions made in accordance with rate revision or audit procedures.

For personal care services provided by or under arrangements with individual providers, payment is made directly to the individual provider at a rate approved by the Department and the Director of the Budget.

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[6(A)(i)(a)]6(a)(i)(1)**

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(07/06)**

For personal care services provided directly by social services district staff, payment is made according to a salary schedule established by the social services district.

For personal care services provided in family care home certified or operated by the Office of Mental Health (OMH) [or the Office of Mental Retardation and Developmental Disabilities (OMRDD)], payment is made in accordance with a fee schedule developed by OMH [or OMRDD, as appropriate,] and approved by the Department and the Director of the Budget.

[For personal care services provided in community residences certified or operated by the Office of Mental Retardation and Developmental Disabilities (OMRDD), payment is made at hourly rates developed by OMRDD and approved by the Department and the Director of the Budget.]

**Personal Care Services (limited)**

The Commissioner of Health, subject to the approval of the Director of the Budget, establishes reimbursement rates for certain personal care services provided to eligible residents by a certified operator of an adult home or enriched housing program that has been issued a limited license by the Department. A limited license may be issued to the certified operator of an adult home or enriched housing program and allows such operator to directly provide certain personal care and nursing services to residents of the adult home or enriched housing program governed by the terms of the limited license. The personal care services for which reimbursement shall be provided are Level II personal care services, including related nursing supervision, as authorized by the Commissioner, provided however, that the services provided are not personal care services that must otherwise be provided to residents of adult homes or enriched housing programs and, provided further, that reimbursement for Level II personal care services shall not include reimbursement for Level I nutritional and environmental support functions. Regional quarter hour rates are established utilizing weighted average Level II personal care rates for the respective regions for direct care and training, capital, and criminal checks, plus no more than fifteen percent of such rates for administrative expenses.

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**OFFICIAL**New York  
6(a)(ii)Attachment 4.19-B  
(07/07)**Personal Care Agency - Insurance Costs**

The Commissioner of Health is authorized to provide for increased payments to personal care agencies to support increased employee fringe benefit costs associated with the agencies' provision of enhanced health care coverage for their employees.

The cost of such health care related increased employee fringe benefits is a reimbursable cost for eligible personal care agencies. Eligible personal care agencies [, as determined by the Commissioner of Health,] are those agencies whose workers are employed in cities within the state which have populations in excess of one million persons [and] or counties within the state which have populations in excess of [one million persons] nine hundred thousand persons if the county is located within the metropolitan commuter transportation district and meet the following conditions: (a) at least fifty percent of the [persons receiving services from] actual total hours of service for the period July 1, 2007 through March 31, 2008 provided by such employers are provided to recipients of medical assistance; and (b) the employer contributes to a group health insurance plan or employer based group health plan on behalf of such employees; and (c) no benefits are provided under the group health insurance plan or employer based group health plan in excess of the benefits provided to the majority of hospital workers in the community in which the personal care workers are employed].

[Total] Medicaid payments to eligible personal care agencies are based on total funds available for this program, allocated proportionately by Medicaid hours of service provided by each eligible provider. [the documented approved costs of the eligible agency for group health insurance premiums paid for their employed personal care attendants and allocable to the Medicaid hours of service provided by such employees.] Payments may, in the aggregate, and on an annual basis, be no more than \$58,000,000 provided however, that for the period October 2 through December 31, 2003, the amount will increase by \$105,000,000; and for annual periods [on and after] January 1, 2004 through June 30, 2007, the amount of funding shall be no more than \$163,000,000 in the aggregate. For the period July 1, 2007 through March 31, 2008, the amount of funding shall be \$122,300,000 in the aggregate for all eligible certified home health agencies and personal care providers. Rates of payment shall be adjusted for eligible providers and allocated proportionally [to reflect the Medicaid share of the approved costs] based on the [proportional] relationship of the provider's Medicaid annual hours of service [care rendered to Medicaid beneficiaries] to the total Medicaid annual hours of service [care] rendered [to] by all of the providers [patients], based upon each provider's actual Medicaid hours of service for which payment has been made by the State's Medicaid Management Information System for the period July 1, 2007 through March 31, 2008.

TN #07-32 \_\_\_\_\_

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**OFFICIAL**

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(07/07)

Eligible providers shall use such funds solely for the purpose of supporting health insurance coverage for their employees and are prohibited from using such funds for any other purpose. The Commissioner is authorized to audit such providers for the purpose of ensuring compliance and shall recoup any funds determined to have been used for purposes other than those authorized.

[The Commissioner may modify the amounts made available for any specific annual period so long as the total amount made available for the period is not exceeded.] The effective period is January 1, 2000 through [June 30, 2007] March 31, 2008.

The Commissioner of Health is authorized to require group health insurance plans and employer based group health plans to report to the Department, insofar as such reporting does not violate any provisions the Federal Employee Retirement Income Security Act (ERISA), at such times and in such manner as the Commissioner shall decide, any information, including but not limited to, the number of people in such plans who become ineligible each month for the continuation coverage described herein. In addition every certified health maintenance organization and every insurer licensed by the Superintendent of Insurance shall submit reports in such form and at such times as may be required.

#### **Criminal Background Checks for Personal Care Service Agencies**

Effective April 1, 2005, personal care service agencies must obtain a criminal history record check from the United States Attorney General for any prospective unlicensed direct care employee. This includes obtaining, as part of an application for employment, all information from a prospective employee necessary for initiating the criminal history record check, including, but not limited to, a finger print card of the prospective employee. The federal fee and the costs associated with obtaining the fingerprint card shall be separately identified on any report of costs submitted to the Department of Health and shall be deemed an allowable cost for Medicaid rates of payment. Reimbursement for the period April 1, 2005 through March 31, 2006 and for the period April 1, 2006 through August 31, 2006, shall be made retrospectively based upon cost reports submitted for the 2005 and 2006 rate years, respectively. For new providers or existing providers for which cost report data is unavailable, payment will be based on budgeted costs and subsequently adjusted to reflect actual costs. Reimbursement for all types of providers shall total no more than \$5,000,000 for the April 1, 2005 through March 31, 2006 period and no more than \$5,600,000 for the April 1, 2006 through August 31, 2006 period. Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current rates of payment and will be determined by the percent of Medicaid utilization to total utilization for each provider. If the total cost for these criminal background checks for all types of providers exceeds the amounts set forth for the specified period, provider specific reimbursement will be reduced proportionally based on each eligible provider's reported costs for criminal background checks to the total costs of criminal background checks of all eligible providers.

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(07/07)

**Accessibility, Quality, and Efficiency of Home Care Services**

The Commissioner of Health shall adjust rates of payment for services provided by personal care service providers for the purpose of enhancing the provision, accessibility, quality, and/or efficiency of home care services. These rate adjustments shall be for the purposes of assisting such providers, located in social services districts that do not include a city with a population of over one million persons, in meeting the cost of:

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(04/08)

- (i) Increased use of technology in the delivery of services, including clinical and administrative management information systems;
- (ii) Specialty training of direct service personnel in dementia care, pediatric care, and/or the care of other conditions or populations with complex needs;
- (iii) Increased auto and travel expenses associated with rising fuel prices, including the increased cost of providing services in remote areas;
- (iv) Providing enhanced access to care for high need populations.

The Commissioner shall increase the rates of payment for eligible providers in an [amount up to an] aggregate amount of \$16,000,000 annually for the periods June 1, 2006 through March 31, 2007, [and] July 1, 2007 through March 31, 2008, and June 1, 2008 through March 31, 2009.

Rates will be adjusted in the form of a uniform percentage add-on as [determined] calculated by the Department, based upon the proportion of total allocated dollars, to the total Medicaid expenditures for covered home care services provided in local social services districts that do not include a city with a population over one million. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

TN #08-33

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**Emergency Medical Services Provider Supplemental Payment**

The Department will supplement Medicaid fee-for-service reimbursements made to emergency medical services providers.

For the period July 1, 2006 to March 31, 2007, the aggregate amount of \$3.0 million and for the period April 1, 2007 to March 31, 2008, the aggregate amount of \$6 million will be available. [For the period May 1, 2008 through March 31, 2009, the aggregate amount of \$5,640,000 million will be available.] For the period March 26, 2009 through March 31, 2009, the aggregate amount of \$4,512,000 will be available.

This payment will be based upon a ratio of individual provider payments to total Medicaid provider payments in each quarter of the state fiscal year.

The following methodology applies in each state fiscal year:

- The aggregate amount will be divided by four as a payment will be made in each quarter of the state fiscal year, and further divided as follows:
  - Twenty five percent of the total aggregate amount will be paid to providers within the City of New York.
    - The Department will determine the ratio of an emergency medical services Medicaid provider's Medicaid reimbursements to the total Medicaid payments made to emergency medical services providers during that quarter of the state fiscal year to providers within the City of New York, and will express that ratio as a percentage.
    - The Department will then multiply the percentage by one-quarter the supplemental amount available to be disbursed for emergency medical services providers based in the City of New York. The result of such calculation shall represent the "emergency medical service supplemental payment".
    - In each quarter of the state fiscal year, these steps shall be repeated.
  - Seventy-five percent of the total aggregate amount will be paid to Medicaid providers outside the City of New York.
    - The Department will determine the ratio of an emergency medical services Medicaid provider's Medicaid reimbursements to the total Medicaid payments made to emergency medical services providers during that quarter of the state fiscal year to providers outside the City of New York, and will express that ratio as a percentage.
    - The Department will then multiply the percentage by one quarter the supplemental amount available to be disbursed to providers based outside the City of New York. The result of such calculation shall represent the "emergency medical service supplemental payment".
    - In each quarter of the state fiscal year, these steps shall be repeated.

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New York

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(9/00)

RESERVED

TM 00-05

99-01

Approved For: JAN 08 2001

JAN 01 2000

New York  
7(a)

Attachment 4.19B  
(02/00)

Section 86-2.9, Adult Day Health Care in Residential Health Care Facilities, is hereby amended to read as follows:

Section 86-2.9 Adult Day Health Care in Residential Health care Facilities: (a) Except as specifically identified in subdivision (g), rates for residential health care facility services for adult day health care registrants shall be computed on the basis of the allowable costs, as reported by the residential health care facility, and the total number of visits by adult day health care registrants, as defined in Part 425 of this Title, for which services were delivered pursuant to Article 6 of Subchapter A of Chapter V of this Title subject to the maximum daily rate provided for in this section.

(b) For adult day health care programs without adequate cost experience, rates will be computed based upon annual budgeted allowable costs, as submitted by the residential health care facility and the total estimated annual number of visits by adult day health care registrants, as defined in Part 425 of this Title, for which services were delivered pursuant to Article 6 of Subchapter A of this Title subject to the maximum daily rate provided for in this section.

TN 00-01 Approval Date JUN 06 2001  
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7(a)(i)

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(4/07)

- (c) Allowable costs shall include, but not be limited to the following:
- (1) applicable salary and non-salary operating costs;
  - (2) costs of transportation; and,
  - (3) appropriate portion of capital costs, allocated according to instructions accompanying the RHCF-4 report.
- (d) the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24 hour period as described in Part 425 of this title shall be 75 percent of the sponsoring facility's former skilled nursing facility rate in effect on January 1, 1990, with the operating component trended forward to the rate year by the sponsoring facility's trend factor.
- (e) notwithstanding subdivision (d) of this section or any other regulations to the contrary, for the period July 1, 1992 to March 31, 1993 and annual periods beginning April 1, 1993 through March 31, 1999, July 1, 1999 through March 31, 2003, April 1, 2003 through March 31, 2005, and from April 1, 2005 through March 31, [2007] 2009, the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24 hour period as described in Part 425 of this Title shall be 65 percent of the sponsoring facility's former skilled nursing facility rate in effect January 1, 1990, with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

For adult day health care facilities, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, minus 0.25%.

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New York

7(b)

86-2.9 (6/94)

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(f) For facilities without a skilled nursing facility rate, computed in accordance with section 86-2.10 or section 86-2.15 of this Subpart, in effect on January 1, 1990, a weighted average rate for each region listed in Appendix 13A of this Title shall be used as the proxy for the facility's January 1, 1990 skilled nursing facility rate in determining the maximum daily rate for such facilities as set forth in subdivisions (d) and (e) of this section. The weighted average rate for each region shall be equal to the statewide weighted average 1990 skilled nursing facility rate with the statewide average direct component and indirect component of the rate adjusted respectively by the regional direct and indirect input price adjustment factors described in section 86-2.10. The statewide weighted average rate shall be computed by multiplying each residential health care facility's 1990 skilled nursing facility rate times its 1990 skilled nursing facility patient days, summing the result statewide, and dividing by the statewide total 1990 skilled nursing facility patient days. The 1990 rate used in computing the statewide weighted average rate shall be the latest 1990 rate in effect on July 1, 1992 for the former skilled nursing level of care which is contained in the rate which has been certified by the commissioner pursuant to section 2807(3) of the Public Health Law.

JUN 26 1994

(g) Effective April 1, 1994 and thereafter reimbursement for Adult Day Health Care services provided to registrants with acquired immunodeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses shall be established as follows. Payment shall be a per visit price with not more than one visit per day per registrant. The rate of payment shall consist of a single price per visit for the operating component, transportation, and the capital cost component and shall be based upon a rate of \$160 per visit per 24 hour period. To be eligible for reimbursement a residential health care facility must be certified by the Department to provide adult day health care services for AIDS/HIV registrants. The price shall be full reimbursement for the following: (i) physician services, nursing services, and other related professional expenses directly incurred by the licensed residential health care facility; (ii) administrative, personnel, business office, data processing, recordkeeping, housekeeping, food services, transportation, plant operation and maintenance and other related facility overhead expenses; (iii) all other services required for adult day health care in residential health care facilities appropriate to the level of general medical care required by the patient; (iv) all medical supplies, immunizations, and drugs directly related to the provision of services except for those drugs used to treat AIDS

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Supersede TN 43

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patients for which fee-for-service reimbursement is available as determined by the Department of Health.

Medical assistance rates of payment for adult day health care services provided on and after December 1, 2002 to patients with AIDS/HIV by a residential health care facility shall be increased by three percent.

This increase to rates of payment will be for purposes of improving recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Programs are prohibited from using the funds for any other purpose. The Commissioner of Health is authorized to audit each program to ensure compliance with the purpose for which this funding is provided and shall recoup any funds determined to have been used for purposes other than recruitment and retention.

To generate a threshold day care bill, the provider must ensure that clients receive a core service and be in attendance for a minimum of three hours, and over the course of the week, receive a minimum of three hours of health care services. Health care services are defined as both the core services and health related services that are therapeutic in nature and directly or indirectly related to the core services, which must be identified on the client's comprehensive care plan. Each visit must include a core service. A bill cannot be generated if these two requirements are not met.

**Core services include:**

- Medical visits
- Nursing visits
- Individual and group Mental Health services
- Individual and group Nutrition counseling services
- Individual and group Substance Abuse counseling services
- Medication group counseling
- Activities of Daily Living
- Physical and Occupational Therapy services
- Case management services
- Prevention/Risk reduction counseling
- Any routine assessment performed by an appropriately credentialed staff person

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**Health related (non-core) services include:**

- Group exercise sessions
- Acupuncture
- Breakfast and/or lunch
- Therapeutic massage
- Yoga
- Pastoral care
- Therapeutic recreation and structured socialization services
- Tai-chi

For adult day health care services provided on and after January 1, 2007, medical assistance rates of payment to residential health care facilities shall be increased up to an annual amount of \$2.8 million in the aggregate. Such amount shall be allocated proportionally among eligible providers based on the medical assistance visits reported by each provider in the most recently available cost report, as submitted to the Department of Health. Such allocated amounts will be included as an adjustment to each provider's daily rate of payment for such services.

For adult day health care services rendered on and after January 1, 2007, through December 31, 2009, and for adult day health care services provided to patients diagnosed with AIDS on and after April 1, 2009, medical assistance rates of payments shall reflect trend factor adjustments computed in accordance with the previously approved trend factor methodology contained on page 1(c)(i) in this Attachment.

- (h) For the period April 1, 2007 and thereafter, rates of payment for adult day health care services provided by residential health care facilities, shall be computed in accordance with the following:
- (i) the operating component of the rate for an adult day health care program that has achieved an occupancy percentage of 90% or greater for a calendar year, prior to April 1, 2007, shall be calculated utilizing allowable costs reported in the 2004, 2005, or 2006 calendar year residential health care facility cost report filed by the sponsoring residential health care facility, whichever is the earliest of such calendar year cost reports in which the program has achieved an occupancy percentage of 90% or greater, except that programs receiving rates of payment based on allowable costs for a period prior to April 1, 2007 shall continue to receive rates of payment based on that period;
  - (ii) for programs that achieved an occupancy percentage of 90% or greater prior to calendar year 2004 but did not maintain occupancy of 90% or greater in calendar years 2004, 2005, or 2006, the operating component of the rate of payment will be calculated utilizing allowable costs reported in the 2004 calendar year cost report divided by visits imputed at 90% occupancy.

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(04/09)

- (iii) programs that have not achieved an occupancy of 90% or greater for a calendar year prior to April 1, 2007, will have the operating component of the rate of payment calculated utilizing allowable costs reported in the first calendar year after 2006 in which the program achieves an occupancy of 90% or greater effective January first of such calendar year except for calendar year 2007, effective no earlier than April first of such year, provided, however, that effective January 1, 2009 programs that have not achieved an occupancy of 90% or greater for a calendar year prior to January 1, 2009, the operating component of the rate of payment will be calculated utilizing allowable costs reported in the 2009 cost report filed by the sponsoring residential health care facility divided by actual visits or imputed at 90% occupancy, whichever is greater. This will also apply to programs which achieve an occupancy percentage of 90% or greater prior to calendar year 2004, but in such year had an approved capacity that was not the same as in calendar year 2004.
- (iv) for residential health care facilities approved to commence operation of an adult day health care program on or after April 1, 2007, rates of payment for these programs will be computed based upon annual budgeted allowable costs, as submitted by the residential health care facility, and total estimated annual visits by adult day health registrants of not less than 90% of licensed occupancy. Each program shall also be required to submit an individual budget. Multiple programs operated by the same residential health care facility shall each have separate rates of payment;
- (v) Rates developed based upon budgets shall remain in effect for no longer than two calendar years from the earlier of:
- (A) the date the program commences operations; or
  - (B) the date the sponsoring residential health care facility submits a full calendar year residential health care facility cost report in which the program has achieved 90% or greater occupancy. If a sponsoring residential health care facility submits such a cost report within two years of the date the program commences operation, rates shall then be computed utilizing that cost report.

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- (vi) If a program fails to achieve 90% or greater occupancy within two calendar years of the date of its commencing operations, rates will be calculated utilizing allowable costs reported in such second calendar year residential health care facility's cost report for the applicable sponsoring residential health care facility divided by visits Imputed at 90% occupancy.
- (vii) Effective January 1, 2008, rates of payment will exclude reimbursement for the costs of transportation:
- (viii) All rates of payment established for adult day health programs operated by residential health care facilities shall be subject to the maximum daily rate otherwise provided by law, provided, however, that such maximum daily rate of payment for adult day health programs operated by residential health care facilities that underwent a change of ownership subsequent to 1990 will be determined by utilizing the inpatient rate of payment of the prior operator as in effect on January 1, 1990, and further provided that in the event a residential health care facility operates an off-site adult day health program outside the regional input price adjustment region in which such facility is located, the computation of the maximum daily rate of payment for that program will utilize the weighted average of the inpatient rates of payments for residential health care facilities in the region in which the program is located, as in effect on January 1, 1990, in place of the sponsoring residential health care facility's inpatient rate of payment.

[86-2.10] Computation of basic rate.

[j] Rates for residential health care facility services for [nonoccupants] non-occupants for 1986 and subsequent rate years shall be calculated in accordance with [section] §86-2.9 of this Subpart, with any operating component of the rate trended from the 1983 base year, to the rate year by the applicable roll factor promulgated by the [d]Department.

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Supersedes TN NEW

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TYPE OF SERVICE

METHOD OF REIMBURSEMENT

Outpatient Hospital Mental Health Services

Intensive Day Treatment Program  
(programs certified by OMH pursuant to 14 NYCRR Part 581)

In accordance with the State Mental Hygiene Law, the Office of Mental Health establishes Medicaid rates of reimbursement for outpatient programs issued operating certificates by the Office. The Intensive Day Treatment program is an outpatient program. Medicaid rates established by the Office of Mental Health must be certified by the Commissioner and approved by Division of the Budget. The methods and standards set forth below do not apply to any other type of outpatient programs licensed by the Office of Mental Health:

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(1) Operating Costs

Medicaid rates for Intensive Day Treatment programs are established prospectively and are all inclusive, taking into account all allowable costs and all allowable visits.

Because Intensive Day Treatment programs have not yet accumulated sufficient cost information to establish cost related rates, operating costs for all Intensive Day Treatment programs are determined on the basis of cost projections contained in budget documents prepared by Intensive Day Treatment programs selected for operation and submitted for review and approval by the Office of Mental Health.

Allowable operating costs include the costs of services approved by the Commissioner. In determining allowability of costs, the Office of Mental health reviews the categories of costs, described below, with consideration given to the special needs of the patient population to be served by the Intensive Day Treatment program. The categories of costs to be reviewed shall include, but not be limited to, the following:

(i) Clinical care. This category of cost includes salaries and fringe benefits for clinical and direct care staff of the program.

(ii) Other than clinical care. This category of cost includes costs associated with administration, maintenance and support expenses.

Allowable operating costs in the category of clinical care are limited to costs approved by the Commissioner in connection with his review of the Intensive Day Treatment programs staffing plan. Allowable operating costs in the category other than clinical care are limited to budgeted costs. The other than clinical costs reported will be reviewed to determine their relative impact within a given program, as well as in comparison to the universe of selected Intensive Day Treatment programs.

Appeals from rate determinations are heard by the Commissioner. The Commissioner may hear requests for rate revisions which are based on errors in the calculation of the rate or in the data submitted by the facility or based on significant changes in operating costs resulting from changes in services, programs or capital projects approved by the Commissioner in connection with the Office of Mental Health's certificate of need procedures. Revised rates must be certified by the Commissioner and approved by the Director of the Budget.

(2) Capital Costs

To allowable operating costs are added allowable capital costs. Allowable capital costs are determined by the application of principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. A return on equity, as determined by the New York State Department of Health, is allowed for proprietary hospitals. To be allowable, capital expenditure subject to the Office of Mental Health's certificate of need procedures must be reviewed and approved by the Office of Mental Health.

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Supersedes FN# \_\_\_\_\_

TYPE OF SERVICE

METHOD OF REIMBURSEMENT

ambulatory Services in Facilities  
Certified Under Article 31 of the State  
Mental Hygiene Law:

OMH Clinic, Day and Continuing  
Treatment Programs

Intensive Day Treatment Program  
(programs certified by OMH pursuant  
to 14 NYCRR Part 581)

Flat fee developed by OMH and approved  
by the Division of the Budget.

[same as that for Intensive Day  
Treatment Program services under  
"Outpatient Hospital Mental Health  
Services"]

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TN# \_\_\_\_\_

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**Types of Service**

**Hospice Services: Routine Home Care, Continuous Home Care, Inpatient Respite Care, And General Inpatient Care**

Medicaid payment for hospice care will be in amounts no lower than the Medicare rates for: general inpatient, inpatient respite, routine home care and continuous home care using the same methodology as used under Part A of Title XVIII. Annual adjustments shall be made to these rates commencing October 1, 1990, using inflation factors developed by the State.

The Commissioner of Health will increase medical assistance rates of payment by three percent for hospice services provided on and after December first, two thousand two, for purposes of improving recruitment and retention of non-supervisory workers or workers with direct patient care responsibility.

For hospice services provided on or after June 1, 2006 through March 31, [2008] 2011, rates of payment will be additionally adjusted for the purpose of further enhancing the provider's ability to recruit and retain non-supervisory workers or workers with direct patient care responsibility. These additional adjustments to rates of payment will be calculated by allocating the available funding proportionally based on each hospice provider's non-supervisory workers or workers with direct patient care responsibility total annual hours of service provided to Medicaid patients as reported in each such provider's most recent cost report as submitted to the Department prior to November 1, 2005, to the total of such hours for all eligible hospice providers. The total aggregate available funding for all eligible hospice providers is as follows:

- For the period June 1, 2006 through December 31, 2006 - \$730,000.
- For the period January 1, 2007 through June 30, 2007 - \$730,000.
- For the period July 1, 2007 through March 31, 2008 - \$1,460,000.
- For the period April 1, 2008 through March 31, 2009 - \$1,460,000.
- For the period April 1, 2009 through March 31, 2010 - \$1,460,000.
- For the period April 1, 2010 through March 31, 2011 - \$1,460,000.

Hospice services providers that have their rates adjusted for this purpose shall use such funds solely for the purposes of recruitment and retention of non-supervisory workers or workers with direct patient care responsibility and are prohibited from using such funds for any other purposes. Each hospice provider receiving funds shall submit, at a time and in a manner determined by the Commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers or workers with direct patient care responsibility. The Commissioner is authorized to audit each provider to ensure compliance with this purpose and shall recoup all funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or workers with direct patient care responsibility. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

TN #08-31

Approval Date APR 09 2008

Supersedes TN #07-13

Effective Date APR 01 2008

New York  
Page 10(a)

**OFFICIAL**

Attachment 4.19-B  
(04/06)

### Type of Service

For persons residing in nursing facilities who have elected hospice care, the Medicaid State agency will pay the hospice an amount sufficient to cover room and board as defined in Section 1905 (o) of the Social Security Act.

### Special Needs Patients

Enhanced Medicaid rates for services to special need hospice patients are established for routine home care, continuous home care and general inpatient care using the following methodology: Use the percentages for each service component as promulgated by the CMS in the routine home care, continuous home care and general inpatient care rates, to determine service component dollar values;

### [Special Needs Patient (cont.)]

[U]se documented cost data which supports specific service component enhancement to calculate amount to be added to rate as an enhancement; [A]pportion each rate into its respective labor and non-labor component using the Medicare prescribed labor to non-labor ratios; [A]adjust labor component of each enhanced rate to account for regional differences in wages using Medicare hospice wage indices; [A]add adjusted labor component to the non-labor component to arrive at the regional enhanced rates.

### Rehabilitative Services

The New York State Office of Alcoholism and Substance Abuse Services establishes rates of reimbursement for the provision of rehabilitative services to persons in freestanding chemical dependence residential facilities. Allowable base year costs are determined by the application of principles developed for determining reasonable cost payments under the Medicare program. To be allowable, costs must be reasonable and relate to patient care. Allowable costs may not include costs for services, which have not been approved by the Commissioner. Total allowable costs are classified as either treatment related costs or room and board related costs. Utilizing only allowable treatment related costs; a provider-specific Medicaid treatment rate shall be established. The treatment rate shall consist of an operating and a capital component.

TN #06-53 \_\_\_\_\_

Approval Date APR 02 2007

Supersedes TN #02-16 \_\_\_\_\_

Effective Date JUN 01 2006

TYPE OF SERVICE

Rehabilitative Services

METHOD OF REIMBURSEMENT

(1) Directly Observed Therapy (DOT)  
The New York State Department of Health establishes a weekly fee for the provision of Directly Observed Therapy. Fees are established to take into account service site, service complexity, service intensity, any existing relationship between the provider and the recipient, record of compliance and completion of therapy. Access to these fees will be available only to those providers who sign Provider Agreements.

Rehabilitative Services

For Freestanding out-patient providers, the Office of Mental Retardation and Developmental Disabilities will utilize established statewide cost related flat clinic fees for off-site services. Fees will be assigned based on provider specific clinic costs or budgets which correspond to the fiscal cycle of the provider. All fees are subject to the approval of the New York State Division of the Budget. Access to these fees will be available only to those providers who enter into Provider Agreements.

TN 92-54 Approval Date DEC 23 1992  
Supersedes TN 92-10 Effective Date SEP 24 1992

New York  
10(1)(A)

Attachment 4.19B  
(6/02)

[TYPE OF SERVICE]

[METHOD OF REIMBURSEMENT]

**Rehabilitative Services**

Reimbursement for approved early intervention providers is associated with resource use patterns to ensure that evaluations and early intervention services are economically and efficiently provided. The method is based on a classification of early intervention services.

Under the reimbursement methodology, individual or combined prices are established prospectively for each service category. For each service category, a price is established to cover labor, administrative overhead; general operating and capital costs. The prices are adjusted to reflect regional differences in costs. The regional classification system used to reflect differences in costs is described in 86-2.10(c)(5) of Attachment 4.19-A of the State Plan. All prices are subject to the approval of the New York State Division of the Budget.

Existing rates of reimbursement, for approved early intervention services provided on and after December 1, 2002, shall be increased by three percent. The Commissioner of Health is authorized to require any early intervention provider, with the exception of self-employed early intervention providers, to submit a written certification attesting that such funds were or will be used solely for the purpose of recruitment and retention of early intervention service providers during the 2002-03 state fiscal year.

Early Intervention service providers who were authorized to provide early intervention services pursuant to section 236 of the Family Court Act during 1993, shall be reimbursed actual allowable capital costs obligated prior to July 1, 1993. Such reimbursement will continue through June 30, 1996.

TN 02-45

Supersedes TN

~~96-47~~  
(96-47)

Approval Date

FEB 27 2003

Effective Date

DEC 31 2002

Specialized programs for residents requiring behavioral interventions.

(a) General.

(1) Specialized programs for residents requiring behavioral interventions ("the program") shall mean a discrete unit with a planned combination of services with staffing, equipment and physical facilities designed to serve individuals whose severe behavior cannot be managed in a less restrictive setting. The program shall provide goal-directed, comprehensive and interdisciplinary services directed at attaining or maintaining the individual at the highest practicable level of physical, affective, behavioral and cognitive functioning.

(2) The program shall serve residents who are a danger to self or others and who display violent or aggressive behaviors which are typically exhibited as physical or verbal aggression such as clear threats of violence. This behavior may be unpredictable, recurrent for no apparent reason, and typically exhibited as assaultive, combative, disruptive or socially inappropriate behavior such as sexual molestation or fire setting.

(3) The program shall be located in a nursing unit which is specifically designated for this purpose and physically separate from other facility residents. The unit shall be designed in accordance with the provisions as set forth in Subpart 713-2 of this Title.

(4) The facility shall have a written agreement with an inpatient psychiatric facility licensed under the Mental Hygiene Law to provide for inpatient admissions and consultative services as needed.

(5) In addition to the implementation of the quality assessment and assurance plan for this program as required by section 415.27 of this Part, the facility shall participate with the commissioner or his or her designee in a review of the program and resident outcomes. The factors to be reviewed shall include but not be limited to a review of admissions, the care and services provided, continued stays, and discharge planning. The facility shall furnish records, reports and data in a format as requested by the commissioner or his or her designee and shall make available for participation in the review, as necessary, members of the interdisciplinary resident care team.

(b) Admission.

TN 94-04

SEP 8 1988

Supersedes TN New

Approved

Dec

Jan

(1) The facility shall develop written admission criteria which are applied to each prospective resident. As a minimum, for residents admitted to the program, there shall be documented evidence in the resident's medical record that:

- (i) the resident's behavior is dangerous to him or herself or to others;
- (ii) the resident's behavior has been assessed according to severity and intensity;
- (iii) within 30 days prior to the date of application to the program, the resident has displayed:
  - (a) verbal aggression which constitutes a clear threat of violence towards others or self; or
  - (b) physical aggression which is assaultive or combative and causes or is likely to cause harm to others or self; or
  - (c) persistently regressive or socially inappropriate behavior which causes actual harm.
- (iv) various alternative interventions have been tried and found to be unsuccessful;
- (v) the resident cannot be managed in a less restrictive setting; and
- (vi) the prospective resident has the ability to benefit from such a program.

(2) Prior to admission, the facility shall fully inform the resident and the resident's designated representative both orally and in writing about the program plan and the policies and procedures governing resident care in this unit. Such policies and procedures shall at a minimum include a statement that the resident's right to leave or be discharged from the program shall be consistent with the rights of other residents in the facility.

(c) Assessment and Care Planning.

(1) The interdisciplinary team shall have determined preliminary approaches and interventions to the severe behavior and recorded them in the resident care plan prior to admission to the unit.

(2) Each resident's care plan shall include care and services which are therapeutically beneficial for the resident and selected by the resident

TN 14-04 Approval Date SEP 10 1999

Supersedes TN 14-04 .IAM .

when able and as appropriate. The care plan shall be prepared by the interdisciplinary team, as described in section 415.11 of this Part, which shall include psychiatrist, psychologist, or social worker participation as appropriate to the needs of the resident.

(3) Based on the resident's response to therapeutic interventions, the care plan including the discharge plan shall be reviewed and modified, as needed, but at least once a month.

(d) Discharge.

(1) A proposed discharge plan shall be developed within 30 days of admission for each resident as part of the overall care plan and shall include input from all professionals caring for the resident, the resident and his or her family, as appropriate, and any outside agency or resource that will be involved with the resident following discharge.

(2) When the interdisciplinary team determines that discharge of a resident to another facility or community-based program is appropriate, a discharge plan shall be implemented which is designed to assist and support the resident, family and caregiver in the transition to the new setting. Program staff shall be available post-discharge to act as a continuing resource for the resident, family or caregiver.

(3) The resident shall be discharged to a less restrictive setting when he or she no longer meets the admission criteria for this program as stated in subdivision (b) of this section.

(4) A resident discharged to an acute care facility shall be accompanied by a member of the program's direct care staff during transfer. He or she shall be given priority readmission status to the program as his or her condition may warrant.

(5) There shall be a written transfer agreement with any nursing home of origin which allows for priority readmission to such transferring facility when a resident is capable of a safe discharge.

(e) Resident services and staffing requirements.

(1) The program shall consist of a variety of medical, behavioral, counseling, recreational, exercise, and other services to help the resident control or redirect his or her behavior through interventions carried out in a therapeutic environment provided on-site.

(2) There shall be dedicated staffing in sufficient numbers to provide for the direct services in the unit and to allow for small group activities and for one-on-one care.

TN 94-04 Approval Date SEP 18 1998  
Supersedes TN **New**

(3) The unit shall be managed by a program coordinator who is a licensed or certified health care professional with previous formal education, training and experience in the administration of a program concerned with the care and management of individuals with severe behavioral problems. The program coordinator shall be responsible for the operation and oversight of the program. Other responsibilities of the program coordinator shall include:

- (i) the planning for and coordination of direct care and services;
- (ii) developing and implementing inservice and continuing education programs, in collaboration with the interdisciplinary team, for all staff in contact with or working with these residents;
- (iii) participation in the facility's decisions regarding resident care and services that affect the operation of the unit; and
- (iv) ensuring the development and implementation of a program plan and policies and procedures specific to this program.

(4) A physician who has specialized training and experience in the care of individuals with severe behavioral or neuropsychiatric conditions shall be responsible for the medical direction and medical oversight of this program and shall assist with the development and evaluation of policies and procedures governing the provision of medical services in this unit.

(5) A qualified specialist in psychiatry who has clinical experience in behavioral medicine and experience working with individuals who are neurologically impaired shall be available on staff or a consulting basis to the residents and to the program.

(6) A clinical psychologist with at least one year of training in neuropsychology shall be available on staff or a consulting basis to the residents and to the program.

(7) A social worker with experience associated with severe behavioral conditions shall be available either on staff or a consulting basis to work with the residents, staff and family as needed.

(8) Other than the program coordinator, there shall be at least one registered professional nurse deployed on each shift in this unit who has training and experience in caring for individuals with severe behaviors.

(9) A full-time therapeutic recreation specialist shall be responsible

RE: SUPER STATE DEPARTMENT OF HEALTH 28

for the therapeutic recreation program.

(10) The facility shall ensure that all staff assigned to the direct care of the residents have pertinent experience or have received training in the care and management of individuals with severe behaviors.

(11) The facility shall ensure that educational programs are conducted for staff not providing direct care but who come in contact with these residents on a regular basis such as housekeeping and dietary aides. The programs shall familiarize staff with the program and the residents.

Volume: 10C

DEPT. OF PUBLIC HEALTH, DIVISION OF HEALTH SERVICES, MIAMI, FLORIDA

TN 44-04 Approval Date SEP 18 1990  
Supersedes TN **New**

ATTACHMENT 4.19E

DEFINITION OF A CLAIM BY TYPE OF SERVICE

A claim is defined as a request for reimbursement for medical services rendered to an eligible Medicaid recipient.

Claims must be submitted on acceptable claim forms.

- 1) Claim Form A - used by Practitioners (physicians, podiatrists, private duty nurses, therapists, clinical psychologists), Clinics (Outpatient and Free-Standing), Dental providers, (private practicing, schools and clinics), Laboratories, HMO's Referred Ambulatory, Home Health, Personal Care Services, Transportation and Eye Care providers.
- 2) Practitioner Claim Form - used by Physicians.
- 3) Claim Form B - used by Skilled Nursing Facilities, Health Related Facilities, Child Care Agencies and Intermediate Care Facilities.
- 4) Claim Form C - used by Hearing Aid dealers and Durable Medical Supplies, Equipment and Appliances vendors.
- 5) UBF-1-81 - used by Inpatient Hospital providers.
- 6) Pharmacy Claim Form - used by pharmacy providers.
- 7) Child Health Assurance Program Claims and report Form - used by physicians and clinics to bill for services rendered under the CHAP (EPSDT) program.
- 8) Universal Physican Claim Form - (New York State's modification of the HCFA-1500) (when implemented will be used by physicians).

Claims are submitted either using the approved rate for each service or billing on a fee-for-service basis.

Providers which submit claims on a fee-for-service basis include:

- Physicians/CHAP physicians
- Podiatrists
- Private Duty Nurses
- Therapists
- Clinical Psychologists
- Pharmacies
- Dentists (private practice, dental school)
- Laboratories
- Eye Care
- Referred Ambulatory
- Transportation
- Durable Medical Supplies, Equipment, Appliances
- Hearing Aid Dealers

Providers which submit claims based on a rate include:

- Outpatient Clinics
- Free Standing Clinics
- Inpatient Hospital
- Skilled Nursing Facilities
- Health Related Facilities
- HMO
- Home Health Agencies (including Long Term Home Health)
- Personal Care Services
- Child Care Agencies
- Intermediate Care Facilities/MR

Revision: HCFM-PM-90-2 (BPD)  
January 1990

State/Territory: New York

1. Frequency of Data Exchanges

433.138(d)(1) State Wage Information Collection Agency (SWICA) and SSA Wage and Earnings File.

Matches with the SWICA in NYS are performed daily and quarterly. Matches with SSA Wage and Earnings files occur monthly.

433.138(d)(3) State Title IV-A Agency.

In New York State, all potentially employable recipients are matched with an employee file from the Department of Labor. Since these recipients and their resources are carried on a single eligibility file, a data exchange is not needed.

433.138(d)(4)(i) State Worker's Compensation.

A match with Worker's Compensation is performed on an annual basis.

433.138(d)(4)(ii) Department of Motor Vehicle Accident File.

This is conducted on an annual basis.

433.138(e) Diagnosis and Trauma Code Edit

The Department uses diagnosis and trauma codes and provider entered accident indicator codes on a monthly basis to determine the legal liability of third parties.

TN 90-19 Approval Date JAN 26 1995

Supersedes TN 87-49 Effective Date APR 1 - 1990

2. Follow-up Requirements

433.138(g)(1)(i) SWICA, SSA Wage and Earning Files and Title IV-A Data Exchanges.

Districts are required to follow-up on information obtained during initial application and redetermination so that it can be used for claims processing and/or recoveries within 60 days of the district first becoming aware of it.

433.138(g)(2)(i) Health Insurance Information and Worker's Compensation.

The Department has issued an Administrative Directive to all local district eligibility and Third Party Workers that establishes procedures for identifying third party resources and requires entering the information on the data base within 60 days so it can be used for claims processing.

433.138 (d)(4)(ii) Department of Motor Vehicle.

If the match identifies a Medicaid recipient who was involved in an auto accident, a questionnaire is sent to the recipient to determine if any medical services were necessary as a result of the accident. Questions are also asked about insurance coverage.

If a positive response is received, it is sent to the local district which has fiscal responsibility for the recipient. The local district is instructed to investigate the potential liability and pursue recoveries when necessary. If medical services are still being provided as a result of the accident, the coverage is added to MMIS to affect claims processing.

433.138(e) Diagnosis and Trauma Code Follow-up.

The Department has been editing claims using diagnosis and trauma codes as well as provider entered accident indicator codes since MMIS was implemented. Through this experience, which has included extensive analysis by local district staff, the Department has developed an efficient program to pursue potential liability for accident/casualty cases.

TN 90-19 Approval Date JAN 26 1995

Supersedes TN 87-49 Effective Date APR 1 1995

433.138(e) Diagnosis and Trauma Code Follow-up (cont.)

On a monthly basis, claims that meet the criteria using trauma diagnosis codes and accident indicators are selected and are used to generate questionnaires to both the recipient and the medical provider for further information concerning the accident. If the questionnaires are not returned, a follow-up letter is sent to the provider and/or recipient. If either questionnaire is returned indicating the potential for a third party to pay for medical expenses, the questionnaire is forwarded to the local district that has fiscal responsibility for the recipient. After the local district has investigated the potential resource a lien is filed if a third party is found to be liable. In any event the Department is to be notified of the outcome of the local district investigation.

The information will only be added to the data base where a provision for medical coverage is involved and it is expected that the recipient will require additional medical services past the date of accident.

TN 90-19 Approval Date JAN 26 1995  
Supersedes TN New Effective Date APR 1 - 1990

Revision: HCFA-PM-90-2 (BPD)  
January 1990

State/Territory: New York

1. Providers Compliance with 433.139(b)(3)(ii)(C).

Compliance with these billing requirements is determined through third party edits in MMIS. If the Medicaid recipient is covered by insurance that is furnished through medical support enforcement carried out by the State IV-D agency, the claim is denied if the specific medical service is covered by the insurance and the provider fails to indicate that the third party was billed by making a positive entry in the other insurance payment field on the claim form.

2&3. Threshold Amount 433.139(F)(2) and (3).

New York State will continue to pursue third party reimbursement through cost avoidance in the first instance by requiring providers to pursue third party resources prior to submitting claims to Medicaid. However, upon discovering insurance which was previously unknown or not utilized, the State will elect not to pursue any potential recovery below threshold amounts periodically established to represent a cost effective return for particular classes of cases. Claims may be accumulated for a period not to exceed two years, for purposes of recovery.

Specific exceptions to this policy include but are not restricted to the following:

- Where accumulated amounts of claims per individual, carrier or provider provide a cost effective basis to submit claims for reimbursement.
- The deterrent effect of recovery is felt to outweigh the administrative cost of claims submission.
- Special audit situations which warrant a recovery based on the specific merits of the case.
- Technological advances which allow computer techniques to be utilized to provide an efficient submission procedure.

TN 90-19 Approval Date JAN 26 1995

Supersedes TN 87-49 Effective Date APR 1 - 1990

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

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Citation

Condition or Requirement

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1906 of the Act

State Method on Cost Effectiveness of  
Employer-Based Group Health Plans

The determination of cost benefit for any health insurance policy is an evaluation of many varied but interrelated criteria. It is difficult to establish exact guidelines for cost benefit determinations that can be applied uniformly in all cases. Unless a person is already in poor health, whenever insurance is purchased a risk is taken as to whether or not health expenses will be incurred. Therefore, cost benefit determinations must be made on an individual basis after the local district or Department of Health staff obtain information about the insurance policy and the individual applying for the premium payment. If the average Medicaid payment is known for certain demographics (e.g., sex, age, location), cost effectiveness for paying the premium can be easily determined by comparing that cost to the cost of a premium for the same demographics.

Please note that for some cases, even after reviewing these criteria, the determination to pay for a health insurance policy may still be unclear. In these cases, the final decision will rest solely on the judgement of local district or Department of Health staff.

The following points should be considered at the time of determination and redetermination for coverage provided through employer-based group health plans.

1. Assess the types of medical services covered by the health insurance policies.
2. Has there been a high utilization of medical services by the applicant/recipient (A/R)? Request the applicant/recipient to bring to the interview all medical bills (paid and unpaid), statements of insurance benefit payments and premium notice for the past year. Determine the total amount paid by all parties for the medical services.

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TN No. 00-05  
Supercedes  
TN No. 91-54

Approval Date JAN 08 2001  
Effective Date JAN 01 2000

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: New York

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

3. Can the past utilization of medical expenses be expected to continue or increase?

During the interview, inquire if any acute or chronic medical conditions exist. If so, does the condition require or could it potentially require extensive medical services? Will these potential expenses be covered by the policy?

4. Does a situation exist which warrants maintaining the policy even through there is no history of high medical utilization.

Due to the client's age or a pre-existing condition, is it reasonable to assume that the client may not be able to obtain another policy in the future or that a pre-existing condition would not be covered by a new policy for a period where medical utilization may be expected?

5. For policies in force, what are the maximum benefit levels of the policy?

- Have the maximum benefit levels been met, rendering the A/R ineligible for benefits?
- If so, is the maximum benefit recurring? Will it be reinstated on an annual basis, at the end of a specific benefit period, or does it apply separately to unrelated injuries, sicknesses, and/or conditions?
- If there will be benefits or recurring benefits that will pertain to the A/R's potential medical expenses, how do these benefits compare to the cost of the premium?

6. Review the number of dependents in a family. In general, the larger the family, the more cost beneficial it is to purchase family coverage.

7. Compare the cost of the premium to the cost of all medical services received by the applicant/recipient in the previous year (see #2). Using this comparison and the other factors related to anticipated future utilization (3 through 6) decide whether or not it is cost beneficial to maintain the policy. That is, does the cost of the premium payment and cost-sharing amounts appear likely to be less than Medicaid expenditures for an equivalent set of services?

NOTE: For those districts that use the [Health Insurance Automated Decision Tree] "Health Insurance Cost Appraisal Program (HICAP)" make sure that the premium payment used in the calculation is the Medicaid portion of the premium payment.

TN 00-05  
Supersedes TN 91-54

Approval Date JAN 08 2001  
Effective Date: JAN 01 2000

**OFFICIAL**

SUPPLEMENT TO ATTACHMENT 4.22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State :     New York    

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE  
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(A)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

TN #09-58

Approval Date SEP 22 2009

Supersedes TN New

Effective Date APR 01 2009

State/Territory: \_\_\_\_\_

Citation

1902(y)(1),  
1902(y)(2)(A),  
and Section  
1902(y)(3)  
of the Act  
(P.L. 101-508,  
Section 4755(a)(2))

1902(y)(1)(A)  
of the Act

(y)(1)(B)  
of Act

1902(y)(2)(A)  
of the Act

Sanctions for Psychiatric Hospitals

- (a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
- (b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
- (c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:
1. terminate the hospital's participation under the State plan; or
  2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or
  3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
- (d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

TN No. 92-67  
Supersedes  
TN No. New

Approval Date MAR 23 1993

Effective Date OCT 1 - 1992

**OFFICIAL**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State:     New York    

**Income and Eligibility Verification System Procedures  
Requests to Other State Agencies**

[New York State does not routinely match or request information from any other State in order to verify Medicaid eligibility.]

New York State routinely matches its Medicaid recipient/applicant files against:

- 1) New York State employee payroll file;
- 2) Death Certificates filed with the New York State Department of Health; and
- 3) Public Assistance Reporting Information System (PARIS), a system that matches data from federal and state public assistance programs.

TN#:     10-24    

Approval Date:     DEC 02 2010    

Supersedes TN#:     86-28    

Effective Date:     JAN 01 2010

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS  
TO HOMELESS INDIVIDUALS

87 35A

New York will mail an ID card to any address indicated by the otherwise eligible client. This includes Post Office boxes as well as residential addresses or other addresses of convenience.

TN No. 87-35A  
Supersedes  
TN No. -----

Approval Date MAR 26 1990

Effective Date JUL 01 1987

HCFA ID: 1080P/0020P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS  
FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

Established by Chapter 752 of the Laws of 1990 by adding Article 29-c of the Public Health Law. Establishes in statute the right of a competent adult to appoint a health care agent to make decisions about health care treatment for the adult in the event the adult no longer has the capacity to make such decisions.

The law confers no new rights regarding the provision or rejection of any specific health care treatment and affirms existing laws and policies which limit individual conduct, including those laws and policies against homicide, suicide, assisted suicide and mercy killing.

The following are definitions that are applicable:

"Adult" means any person who is eighteen years of age or older, or is the parent of a child, or has married.

"Capacity to make health care decisions" means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision:

"Health Care" means any treatment, service or procedure to diagnose or treat an individual's physical or mental condition.

"Health Care Agent" or "Agent" means an adult to whom authority to make health care decisions is delegated under a health care proxy.

"Health Care Decision" means any decision to consent or refuse to consent to health care.

"Health Care Proxy" means a document delegating the authority to make health care decisions, executed in accordance with the requirements of this law.

Provision: HCFA-PM-95-4 (HSQB)  
June 1995

Attachment 4.35-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

New York State will use the factors described at §488.404(b)(1) to determine the seriousness of deficiencies.

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TR No. 95-33

Supersedes

TR No. 90-19

Approval Date: MAR 07 1997

Effective Date: JUL 01 1995

Provision: HCFA-PM-95-4 (HSQB)  
June 1995

Attachment 4.35-B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

Specified Remedy

Will use the criteria and notice requirements specified in the regulation.

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TR No. 95-33  
Supersedes  
TR No. 90-19

Approval Date: MAR 07 1997

Effective Date: JUL 01 1995

Provision: HCFA-PM-95-4 (HSQB)  
June 1995

Attachment 4.35-C

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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Temporary Management: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Appointment of Temporary Management (Alternative)

New York State provides under §2806-b of the Public Health Law pertaining to caretakers and §2810 of the Public Health Law pertaining to receivers, for management of a facility to assure resident health and safety and an orderly closure or correction of requirements. These receivers and caretakers must pass a character and competence review.

The caretaker/receiver remedy described above is being submitted as an alternative remedy. It is more stringent than OBRA '87 requirements for facilities with care problems so serious as to warrant new management imposed by the state and that control not be returned to the same operator. Our experience has demonstrated great success in gaining court support for the appointment of caretakers or receivers under our current provisions. In instances of immediate jeopardy, §2806-b(c) calls for the caretaker to be appointed under the provisions specified in §2810(2). This procedure allows the state's request for a caretaker appointment to be before a Supreme Court judge 5 days after notice of the caretaker action is given to the provider. The notice is given immediately upon the state decision that a caretaker is necessary.

Over the last 10 years, 25 facilities have had receivers utilized on a voluntary or involuntary basis to resolve care issues.

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TR No. 05-33  
Supersedes  
TR No. None

Approval Date: MAR 07 1997

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**OFFICIAL**

Provision: **HCFA-PM-95-4 (HSQB)**  
**June 1995**

**Attachment 4.35-D**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State/Territory: New York**

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

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**Enforcement of Compliance for Nursing Facilities**

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Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

**Specified Remedy**

(Will use the criteria and notice requirements specified in the regulation).

**Alternative Remedy**

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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TR No. **95-33**  
Supersedes **None**  
TR No. **None**

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June 1995

Attachment 4.35-E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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TR No. 95-33  
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TR No. New

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June 1995

Attachment 4.35-F

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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State Monitoring: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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TR No. 95-33  
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Attachment 4.35-G

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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Transfer of Residents: Transfer of Residents with Closure of Facility: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

In Emergency Cases, Closure of Facility and/or Transfer of Residents

Section 2806 of the Public Health Law gives the Commissioner the authority to revoke or suspend a facility's operating certificate and/or transfer residents. Rather than subject residents to unnecessary transfer, Section 2806-b of the Public Health Law is utilized to seek emergency appointment by a court of a caretaker on a temporary basis, to protect the interests of the residents while legal action is taken to revoke the operating certificate of the facility and place the facility in receivership and ultimately under a new operator.

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TR No. 95-33  
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TD No. None

Approval Date: MAR 07 1997

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Attachment 4.35-H

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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Directed Plan of Correction: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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TR No. **New**

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Attachment 4.35-I

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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Directed Inservice Training: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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Attachment 4.35-J

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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**Additional Remedies:** Describe the criteria (as required at §1919(h)(2)(A) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described as 42 CFR 488.408).

**STATE CIVIL MONEY PENALTIES IMPOSED AS A CATEGORY 2 ENFORCEMENT REMEDY**

New York provides under Section 12 of the Public Health law a civil money penalty system which allows fining facilities for each occurrence of a deficiency. A facility may be fined up to \$2,000 for the one time occurrence of any violation of state requirements even if that violation has been corrected. It provides us with the flexibility to evaluate the deficiencies cited, to determine the existence of poor performing facilities, and to fine or not to fine a facility which has corrected the deficiencies, based on the severity and repetitiveness of the violation. Any facility with deficiencies identified with a scope and severity in box (D-L) on the remedy grid will be screened to determine whether a fine will be recommended. Effective October 1, 1990, 10 NYCRR Part 415 was revised and mirrors 42 CFR Part 483 of the federal nursing home requirements in most areas exceeding requirements in some sections. Since the requirements are analogous, compliance with state regulations that might be achieved as a result of utilizing this remedy should also result in a comparable outcome related to the federal requirements also.

State fines will be assessed at a higher level for facilities identified at subsequent surveys with repetitive violations as an incentive to maintain compliance. In some cases a portion of the state fine may be suspended contingent on maintaining compliance with selected regulatory groupings for a specified period of time. Failure to comply with that provision would result in the collection of the suspended fine as well as assuming a new fine for those violations.

This remedy encourages facilities not to allow deficiencies to recur and discourages initial deficiencies, as facilities understand that they cannot allow deficiencies to occur and avoid a penalty by correction within 30 days.

Funds collected by the state from imposition of a penalty are not applied to maintain operation of a facility pending correction or closure or to costs of relocation or to lost resident funds. Facilities in such a situation are monitored by the state to assure that operations are maintained. The Department requires operator(s) to provide a final account of residents' monies. In addition, Public Health Law Section 2810(3) provides a mechanism for non-interest bearing payments to receivers who take over deficient facilities. The receiver must repay such loans.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

Information disclosed by the New York State Nursing Home Nurse Aide Registry in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv)

Individuals' certification number

Date of recertification, if applicable

Last home address of record

Date of birth

Date of conviction of patient abuse, neglect, mistreatment of patients, or misappropriation of resident's property, if any.

TN No. 92-05  
 Supersedes  
 TN No. **New**

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Approval Date APR 29 1992      Effective Date JAN 1 1992  
 HCFA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

New York State Nursing Home Nurse Aide Registry information included on the registry in addition to the information required by 42 CFR 483.156(c)

Maiden name and other surnames used (ASI)

Address of nurse aide when certified/recertified

Date of Birth

Social Security Number

Name/Date of state approved training and competency programs successfully completed

Certification number of nurse aide

Most recent recertification date of nurse aide

Nursing home employer at time of certification/recertification

Date of conviction(s), for patient abuse, neglect, mistreatment of patients, or misappropriation of resident property, if any.

92-05-1  
TN No. \_\_\_\_\_  
Superseded by **New**  
TN No. \_\_\_\_\_  
Approval Date APR 29 1992 Effective Date JAN 1 1992

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**OFFICIAL**

ATTACHMENT 4.39

Page 1

State Plan Under Title XIX of the Social Security Act  
State/Territory: New York

**DEFINITION OF SPECIALIZED SERVICES**

- 1) For mental illness, specialized services means the services specified by the State which [combined with services provided by the NF], result[s] in [the continuous and aggressive implementation of ] an individualized plan of care that demands hospitalization.

The care plan must require one or more of the following:

- a. [Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals, and, as appropriate, other professionals.] Hospital level assessment or diagnosis of recent behavioral change;
- b. [Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and ] Intensive observation, protection, assistance, or supervision from the professional staff of a hospital;
- c. [Is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time]. Introduction or change in medication or other somatic treatment that needs frequent round the clock monitoring by professional staff.

The plan must be developed and supervised by an interdisciplinary team which includes a physician, qualified mental health professionals and, as appropriate, other professionals.

The plan must be directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated hospitalization, so as to improve his or her independent functioning to a level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

- 2) For mental retardation, specialized services means the services specified by the State which, combined with services provided by the NF or other service providers, results in treatment which meets the requirements of Section 483.440(a) (1).

TN#: 08-06

Approval Date: JUL 29 2008

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: New York

CATEGORICAL DETERMINATIONS

Categories for which the State Mental health or mental retardation authority may make an advance group determination that Nursing Facility (NF) services are needed are:

- 1) Convalescent care from an acute physical illness which:
  - (i) Required hospitalization ; and
  - (ii) Does not meet all the criteria for an exempt hospital discharge, which is not subject to preadmission screening as specified in Section 483.106(b)(2).
- 2) Terminal illness, as defined for hospice purposes in Section 413.3 of this chapter.
- 3) Severe physical illness such as coma, ventilator dependence, functioning at a brain stem level, or diagnoses such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, and congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services.
- 4) Very brief and finite stays of up to a fixed number of days to provide respite to in-home caregivers to whom the individual with Mental Illness (MI) or Mental Retardation (MR) is expected to return following the brief NF stay.

93-14  
 TN No. \_\_\_\_\_  
 Supersedes \_\_\_\_\_  
 TN No. **New**  
 Approval Date JUN 28 1993 Effective Date JAN 1 - 1993

Revision: HCFA-PM-92-3 (HSQB)  
APRIL 1992

Attachment 4.40-A  
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OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

- . Health Facility Memorandums - The Health Department's medium for issuing items in the New York State Official Compilation of Codes, Rules and Regulations, and written information on policy and procedures of concern to certified health facilities.
- . Bureau of Long Term Care Staff conduct seminars and training for facility providers.
- . The Health Department contracts with private vendors to present programs to providers.
- . The survey process includes surveyors meeting with the facility's resident council.
- . Ongoing communication occurs between the Bureau of Long Term Care and the State Ombudsman Office.
- . Bureau of Long Term Care Staff meet with the provider associations regarding specific issues on policies and regulations:
- . Bureau of Long Term Care Staff are available by telephone to answer specific provider questions.

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Attachment 4.40-B  
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OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Process for the Investigations of Allegations of Resident Neglect  
and Abuse and Misappropriation of Resident Property

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The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

See Supplement 1A

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Supersedes TN New Effective Date APR 1 - 1992

### Complaint Program Overview

The Department maintains a Patient Abuse Investigation program for investigation of complaints of physical abuse, mistreatment, and neglect. A General Complaint program is maintained for the investigation of complaints involving systemic problems in RHCFS. Complaints involving misappropriation of resident funds are investigated under the General Complaint Program.

The patient abuse reporting legislation was enacted to protect Residential Health Care Facility (RHCF) patients from abuse. The original statute became effective on September 1, 1977, and mandated the immediate reporting of RHCF patient abuse, mistreatment or neglect by certain licensed health care professionals and encouraged reports from all sources.

On September 1, 1980, the statute was amended to require all RHCF employees and licensed health care personnel to make such reports.

The administration of the patient abuse reporting program is the responsibility of the Office of Health Systems Management's Bureau of Long Term Care Services. Following is a brief overview of the administrative procedures associated with the program.

- Reports may be made anytime, night or day, via the Office of Health Systems Management's Hotline. The telephone number for each Office of Health Systems Management Area Office is displayed on the Hotline poster in every RHCF. An emergency contact number for evenings, weekends and holidays (518-445-9989) is also listed. Collect calls are accepted on all numbers.
- Each report to the Office of Health Systems Management is referred to the Deputy Attorney General for Medicaid Fraud Control for possible criminal investigation and to the Local District Attorney if a prior request for such information has been made by the District Attorney. Thirteen (13) such referral arrangements are currently honored. (August 1994)
- Each report is investigated on-site by Office of Health Systems Management Staff within 48 hours. A full investigation is conducted. This may include multiple visits to the residential health care facility, interviews of all involved, and a review of pertinent facility and patient records.
- The investigation results are compiled by the Office of Health Systems Management's Area Offices and forwarded to the Commissioner of Health's Designee for review.

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- The Commissioner of Health's Designee renders a findings that either sustains the allegation of abuse or finds the allegation unsustained. If the allegation is unsustained, all records related to the report are expunged in accordance with the statute and the accused, the facility administrator and all officials previously contacted are notified of the determination. If an allegation is sustained, the accused is notified by certified mail that he/she may request a fair hearing and that as a result of the sustained finding he/she may be liable for a fine of up to \$2,000. The administrator of the facility is also notified of the sustained finding.
- The request for a fair hearing must be made in writing within 30 days of receipt of the finding of the Commissioner of Health's Designee. All fair hearings are scheduled and conducted by the Department of Health's Division of Legal Affairs. The purpose of the hearing is to determine whether the record of the report of the written determination of the sustained finding should be amended or expunged on the grounds that the record is inaccurate or the determination is not supported by the evidence. The burden of proof in such a hearing is on the Office of Health Systems Management. The hearing will determine whether or not the sustained finding will be upheld, and if so, whether or not a fine is to be assessed. In the case of a licensed person, a referral will be made to the appropriate licensing board, and in the case of a certified nurse aide, a referral would be made to the RHCN Nurse Aide Registry.
- 10NYCRR 415.26j requires RHCNs to establish and implement policies and procedures for the receipt, review and investigation of allegations of misappropriation of resident property by individuals in the employ of and/or whose services are utilized by the facility. This is to be done regardless of the monetary value of the property.
- An investigation is required to be made no later than 48 hours after the receipt of the allegation. The facility must maintain a log regarding the receipt, review, investigation, and disposition of every allegation including the name of the complainant and resident, a description of the personal property involved, and the staff designated to conduct the review and investigation.
- Under the General Complaint program, the Department investigates complaints of inadequate response by RHCNs to allegations of misappropriation of resident property. These complaints may be made to the Office of Health Systems Management Hotline as indicated above.

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- The RHCf is required to notify the resident and complainant in writing as to the findings upon disposition of the allegation and to notify the appropriate police agency when the results of the investigation indicate that there is reasonable cause to believe that a resident's personal property valued at more than two hundred fifty dollars has been misappropriated. The RHCf may elect to make such notification when the personal property is valued at less than that amount.
- The RHCf is required to monitor all such referrals at least quarterly and to notify the New York State Department of Health within 72 hours of receipt of notice that such referral resulted in the conviction of an individual who was involved in the misappropriation of resident property.
- Upon receipt of notice of a conviction involving misappropriation of resident property by a nurse aide, the Department provides the individual with an opportunity to dispute the allegations and conviction. Report is then made to the New York State Nurse Aide Registry.
- Upon receipt of notice of a conviction involving misappropriation of resident property involving a licensed professional, a referral is made to the appropriate licensing authority. The licensing authority takes appropriate action after satisfying the individual's due process rights.
- When a referral to the Registry is made of a sustained finding of physical abuse, mistreatment or neglect, or a conviction for misappropriation of resident property, the individual is given an opportunity to provide a brief statement, not exceeding 150 words, disputing the findings provided that this does not name any residents or the complainant.

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● Upon receipt of a written request, the New York State RHCN Nurse Aide Registry provides the following information:

Verification that an individual is a certified nurse aide,

The certification number,

The date of certification/recertification,

Copies of any final findings of resident abuse, mistreatment or neglect by a nurse aide and any statement from the nurse aide disputing the findings.

A report of a criminal conviction for resident abuse, mistreatment, neglect or misappropriation of resident property and the date of conviction.

This information is also available by telephone to RHCNs, nurse aide agencies/employment organizations, and nurse aide registries maintained by other states.

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OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

New York State utilizes the flexible survey schedule which assigns nursing home surveys on a variable interval basis according to facility performance. Poor facilities are surveyed more often, whereas good facilities are surveyed less often. Facilities are surveyed in accordance with the Federal Surveillance process at 6-10 month, 10-13 month and 12-15 month intervals. These wide intervals makes it difficult for nursing homes to predict a general survey date, thus enabling the State to conduct surveys on a surprise basis. The flexible survey schedule ensures the average survey cycle is no more than twelve months.

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Attachment 4.40-D  
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The Bureau of Long Term Care Services evaluates and fosters statewide consistency of the surveillance process. Area Office surveyors are trained to consistently apply federal decision making criteria contained in TASK 6 of Appendix P, Survey Protocol for Long Term Care Facilities. Statements of deficiencies are routinely reviewed by Area Office supervisory staff.

The Central Office Quality Improvement Unit reviews Statements of Deficiencies to ensure statewide uniformity. Area Office Long Term Care Program Directors are informed verbally and in writing of the results of these reviews.

Quality Improvement staff also conduct onsite reviews of the surveillance process. Surveyors performance in regard to consistent application of the survey process is evaluated and feedback is provided to individuals and supervisors.

The Bureau of Long Term Care Services staff respond to code interpretation and surveillance questions from the area offices. These questions and answers are sent to all offices to ensure consistency of code interpretation and application of the survey process.

Various improvement measures to foster consistency are in effect including regularly scheduled meetings with Long Term Care Program Directors from the 6 area offices and workgroups of surveillance staff who are participating in the development of tools to measure and reduce inconsistencies.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: New York State

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

- (i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;
- (ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or
- (iii) the State has reason to question the compliance of the facility with such requirements.

Complaints received by the Area Offices are screened by the Long Term Care Program Director and Team Leader. Based on severity, the complaint is categorized as a 340 (patient abuse or neglect) or a general complaint. If the complaint is determined to be a 340, it is investigated within 48 hours. (See ~~attachment 1A~~ ). General complaints may result in an onsite visit or be investigated at the next surveillance visit. The substance of the general complaint will determine when the onsite visit is completed.

Supplement

Based on the type, number and severity of the complaints received, the Area Office may conduct a focus survey to determine the facility's compliance with the regulations. Monitoring visits may also be conducted to ensure the facility is progressing toward compliance. In addition, prior to the recertification survey all complaints are reviewed in order for surveyors to investigate and determine compliance with all applicable regulations.

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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State/Territory: New York

Citation

1902(a)(68) of  
the Act,  
P.L.109-171  
(section 6032)

Employee Education About False Claims Recoveries.

- (a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1 902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

**(1) Definitions.**

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1 902(a)(68) apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

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health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the \$5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a) (68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

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- (3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
- (4) The requirements of this law should be incorporated into each State's provider enrollment agreements.
- (5) The State will implement this State Plan amendment on 01/01/07 (date).
- (b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

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**OFFICIAL**

Oversight will primarily be the responsibility of the Office of the Medicaid Inspector General, which will incorporate criteria to address these mandates into its periodic audits and investigations.

Under proposed regulatory provisions, each covered provider and entity, as defined in section 4.42(a)(1)(A) above, shall be required to submit to the Office of the Medicaid Inspector General on or before October 1, 2007, and on or before January 1, every year thereafter, a certification that it maintains the written policies, and any employee handbook, required under the above mandates and that they have been properly adopted and published by the provider entity, and disseminated among employees, contractors and agents. The written policies and any employee handbook shall be retained for a period of six years from the latter of the due date or the actual date of submission of the certification.

The Office of the Medicaid Inspector General will review the certifications of the entity, and will also review the written policies and any employee handbook maintained by the entity during audits, for compliance with the Social Security Act, and any additional requirements of which entities are notified. Failure to timely submit the required certifications, or to bring the written policies and any employee handbook into compliance upon reasonable notice from the Medicaid Inspector General, may be considered an unacceptable practice and subject the entity to sanctions and/or penalties. CMS may, at its discretion, independently determine compliance through audits of entities or other means.

In addition, the Medicaid Inspector General will request participation from other state agencies responsible for regulatory oversight and will strongly recommend inclusion of this periodic review during such agencies' routine audits and investigations. These agencies will include:

- Department of Law: Medicaid Fraud Control Unit
- Office of Mental Health
- Department of Health: Offices of Health Systems Management, Professional Medicaid Conduct
- State Education Department: Office of Professions
- Office of Alcoholism and Substance Abuse Services
- Office of Mental Retardation and Developmental Disabilities

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT Attachment 7.2-A  
MEDICAL ASSISTANCE PROGRAM

State of NEW YORK

14

Non discrimination

Currently approved methods of administration under the Civil Rights requirements are on file in the Regional Office.

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NONDISCRIMINATION ON THE BASIS OF HANDICAP  
METHODS OF ADMINISTRATION

1. The Affirmative Action Officer of the New York State Department of Social Services is primarily responsible for insuring compliance with the 45 CFR Part 84 Non-discrimination on the Basis of Handicap Regulations and Section 504 of the Rehabilitation Act of 1973 throughout the Department itself and for all agencies, institutions, organizations and vendors which provide services or benefits. The Bureau of Local Agency Manpower is responsible for compliance with the regulations for the fifty-eight local social service districts.
2. (a) The New York State Department of Social Services has issued a memorandum to all Department employees regarding the regulations. In addition the regulations will be included in the orientation program for all new employees.  
(b) The Department has issued an Administrative Directive to all local social service districts informing them of the provisions of the regulations and instructing them to notify all agencies, institutions, organizations and vendors which provide services as well as instruct them to file the Assurance of Compliance if they have done so. In addition the Directive instructs local service districts to inform all applicants and refer for any of the programs they administer of the provisions of the regulations.  
(c) The Department has published a display advertisement in a number of newspapers throughout the State indicating that the Department complies with the provisions of the regulations.
3. (a) The Affirmative Action Officer will conduct regular reviews of Department practices and policies to assure that no individual is being discriminated against on the basis of handicap.  
(b) The Bureau of Local Agency Manpower will conduct reviews of the local social service districts to assure that they are complying with the provisions of the regulations both in employability and equal availability services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of New York

Methods and Standards for Establishing Payment Rates

Intermediate Care Facilities for the Mentally Retarded

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TN 99-07 Approval Date <sup>June</sup> ~~APR 06~~ 2001  
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~~APR 01~~ 1999  
~~JUL 01~~ 1999

Rate setting and financial reporting for intermediate care facilities for persons with developmental disabilities (ICF/DD). This section is effective [January 1, 1999] January 1, 2003 for under thirty one bed non-state operated facilities classified as Region II and III facilities, [April 1, 1999] April 1, 2003 for all under thirty one bed State operated facilities, and [July 1, 1999] July 1, 2003 for under thirty one bed non-state operated facilities classified as Region I facilities.

(a) Definitions applicable to this section.

(1) Intermediate Care Facilities for the Developmentally Disabled. For the purpose of this section: "Provider" shall mean the individual, corporation, partnership or other organization to which the OMRDD has issued an operating certificate, to operate a facility, or a State owned developmental center and to which the New York State Department of Health has issued a Medicaid provider agreement for such facility. For the purpose of this section: "Facility" shall mean

(i)(a) that program and site for which OMRDD has issued an operating certificate to operate as an intermediate care facility for the developmentally disabled, or

(b) a developmental center which consists of institutional beds, including those beds in Small Residential Units operated by a Developmental Disabilities Services Office (DDSO), but excluding those beds in Small Residential Units operated by a DDSO whose developmental center has closed or is scheduled to close, and

(ii) for which the New York State Department of Health has issued a Medicaid provider agreement.

(2) For the purposes of this section:

(i) A Region I facility is a facility which is located in Region I (other than a facility located in Region I which has been designated or elected to a Region II and III reporting cycle), or a facility which is located in Region II or III which has been designated or elected to a Region I reporting cycle in accordance with 14 NYCRR subpart 635-4.

(ii) A Region II or III facility is a facility which is located in Region II or III (other than a facility located in Region II or III which has been designated or elected to a Region I reporting cycle), or a facility which is located in Region I which has been designated or elected to a Region II or III reporting cycle in accordance with 14 NYCRR subpart 635-4.

(3) Region - The geographic regions are:

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(2) Rate cycle.

- (i) For facilities of over thirty beds, the rate cycle is comprised of two twelve month rate periods.
- (ii) For facilities of under thirty-one beds the rate cycle is comprised of [three twelve month rate periods except that the rate cycles beginning January 1, 1999, April 1, 1999 and July 1, 1999 shall consist of four twelve month rate periods] a base period and subsequent period or periods.

[(iii) This rate cycle is divided into a base period and a subsequent period or periods.]

(a) The base period is the first twelve month period of the rate cycle.

(1) The base period for under thirty one bed non-state operated facilities is from January 1 to December 31 for Region II or III facilities. The first base period for non-state operated facilities begins January 1, 1988 for over thirty bed Region II or III facilities. The [first] base period for non-state operated under thirty one bed facilities begins [January 1, 1999] January 1, 2003 for under thirty-one bed Region II or III facilities.

(2) The base period for under thirty one bed non-state operated facilities is from July 1 to June 30 for Region I facilities. The first base period for non-state operated facilities begins July 1, 1988 for over thirty bed Region I facilities[, and July 1, 1999 ]. The base period for non-state operated facilities begins July 1, 2003 for under thirty-one bed Region I facilities.

(3) For state operated facilities of under 31 beds, regardless of region, the [first] base period shall be [April 1, 1999 to March 31, 2000] April 1, 2003 to March 31, 2004 and shall remain April 1 to March 31 for every rate cycle thereafter. For state operated facilities of more than 30 beds and developmental centers, regardless of region, the first base period shall be April 1, 1988 to March 31, 1989 and shall remain April 1 to March 31 for every rate cycle thereafter.

(b) The subsequent period for over thirty bed facilities is the second twelve month period of the rate cycle. The subsequent periods for under thirty-one bed facilities are the [second and third] subsequent twelve month periods of the rate cycle. [For the rate cycles beginning January 1, 1999, April 1, 1999 and July 1, 1999 there shall be additional

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subsequent period of January 1, 2002 to December 31, 2002; April 1, 2002 to March 31, 2003; and July 1, 2002 to June 30, 2003 for under 31 bed facilities.]

- (1) The subsequent period for non-state operated facilities is from January 1 to December 31 for Region II or III facilities. The first subsequent period begins January 1, 1989 for non-state operated over thirty bed Region II or III facilities. The first subsequent period for non-state operated facilities begins [January 1, 2000] January 1, 2004 for under thirty-one bed Region II or III facilities.
- (2) The subsequent period for non-state operated facilities is from July 1 to June 30 for Region I facilities. The first subsequent period for non-state operated facilities begins July 1, 1989 for over thirty bed Region I facilities. The first subsequent period for non-state operated facilities begins [July 1, 2000] July 1, 2004 for under thirty-one bed Region I facilities.
- (3) For state operated facilities of less than 31 beds, regardless of region, the first subsequent period begins [April 1, 2000] April 1, 2004 and shall remain April to March for every rate cycle thereafter. For developmental centers and state operated facilities over 30 beds, regardless of region, the first subsequent period shall be April 1, 1989 to March 31, 1990 and shall remain April 1 to March 31 for every rate cycle thereafter.

(3) Computation of Rates (General).

- (i) All rates shall not be final unless approved by the Director of the Division of the Budget.
- (ii) The commissioner may make adjustments to rates calculated in accordance with this section based upon the allowability of costs as determined by subdivision (f) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary. In addition, costs may be reallocated and adjusted following a desk audit of cost reports.

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New York

Attachment 4.19-D  
Part II ICF/DD

(a) The desk audit will examine the allocation of costs and OMRDD will reallocate unidentified and improperly classified costs, if any, to appropriate cost categories.

(b) The desk audit will examine base year costs against both the prior and subsequent years' costs. OMRDD will determine if costs are recurring, or are atypical and/or expended only in the base year.

(1) If OMRDD determines that base year costs for a facility are recurring, for the base periods beginning January 1, 2003, April 1, 2003 or July 1, 2003, the methodology described in this section will apply.

(2) If OMRDD determines that base year costs for a facility are atypical and/or were expended only in the base year, OMRDD will expand the desk audit. OMRDD may make adjustments to base year costs so that such costs represent typical and recurring costs.

(3) For a facility whose base year costs are subject to an expanded desk audit per subclause (b)(2) of this subparagraph, OMRDD shall continue the rate in effect on December 31, 2002, March 31, 2003 or June 30, 2003, and, if applicable, trended to 2003 or 2003-2004 dollars, until OMRDD completes the desk audit. For Region II and III facilities, OMRDD shall notify the provider by December 1, 2002 if the December 31, 2002 rate shall continue. For Region I facilities, OMRDD shall notify the provider by June 1, 2003 if the June 30, 2003 rate shall continue. For all State operated facilities, OMRDD shall notify the provider by March 1, 2003 if the March 31, 2003 rate shall continue. Upon OMRDD's completion of the expanded desk audit, for the base periods beginning January 1, 2003, April 1, 2003 or July 1, 2003, the methodology described in this section will apply.

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(c) Administrative review of expanded desk audits shall be in accordance with subdivision 635-4.6(b) of 14 NYCRR

[(ii)](iii) The commissioner may also make adjustments based on errors which occurred in the computation of the rate, changes in certified capacity, changes in payments for real property which have the prior approval of the commissioner and the Director of the Division of the Budget, or changes based upon previously determined final audit findings. If a facility has undergone a change in certified capacity, the commissioner may:

- (a) request the facility to submit a budget report subject to 14 NYCRR subpart 635-4; or
- (b) request the facility to submit incremental/decremental cost data which is associated with the capacity change.
- (c) Utilizing the submitted incremental/decremental data or budget report, OMRDD shall make the appropriate upward or downward adjustment in a facility's rate; or
- (d) continue the then existing rate for the remainder of the subject rate period in those instances where the commissioner has determined that the facility is operating at a loss for the rate period in question and adjusting the current rate would further increase such loss, or the facility is operating at a surplus for the rate period in question and adjusting the rate would further increase such surplus.

[(iii)] (iv) Rate adjustments as described in subparagraph (ii) of this paragraph will be limited to those adjustments which will result in an annual increase or decrease in reimbursement of \$1,000 or more.

[(iv)] (v) Notwithstanding any other provisions of this section, for over thirty bed facilities the reimbursable operating costs contained in the rates shall be computed as follows.

(a) For over thirty bed facilities other than developmental centers, OMRDD shall determine the total reimbursable operating costs (with the exception of education and related service costs, sheltered workshop services, and day training services) included in the payment rate in effect on December 31, March 31 or June 30 of the immediately preceding rate period applicable to that facility.

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The dollars for sheltered workshop and day training services shall be revised based upon the number of individuals participating in the program. The reimbursable operating costs plus any revised sheltered work and day training costs will be increased by the trend factor calculated in subdivision (g) of this section and may be adjusted for appropriate appeals. Education and related services will be updated in accordance with clause (4)(ix)(c) ~~(f)~~ of this subdivision. To determine the capital cost portion of the subsequent period rate, OMRDD shall review the component relating to capital costs for substantial material changes and, if said changes conform to the requirements of paragraphs (f)(1) and (3) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary, make corresponding adjustments in computing the subsequent period rate.

(b)(i) For developmental centers, the statewide average rate for the period from April 1 to March 31 shall be calculated as follows. The total reimbursable operating costs contained in the payment rate in effect on the preceding March 31, with the exception of education and related service costs, after the adjustment for the latest available

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projected number of client days, shall be increased by the trend factor described in subdivision (g) and increased by an amount for education and related services in accordance with clause 4(ix)((c)) (f). In addition, if substantial, material changes that conform to the requirements of subdivision (h) are projected for the rate year these changes may be incorporated into the computation of the April 1 to March 31 period rate without an appeal being filed. OMRDD shall perform a rate year end volume variance adjustment to the April 1 to March 31 period rate for developmental centers by taking into account recalculated operating costs based upon a fixed to variable ratio of 64 percent fixed/36 percent variable, and actual client days.

(ii) In addition, to encourage the closure of developmental centers, the commissioner will allow the net variable costs associated with the planned reduction of the developmental centers to become part of the operating costs of remaining like facilities. Net variable costs are total variable costs less the sum of that portion of the variable costs that become part of the operating costs of new state operated programs and services and the projected personal service attrition savings, as determined using historical attrition trends over the preceding three years, that occur at the developmental centers. The commissioner will allow reimbursement of these net variable costs as part of a plan to close the developmental centers. This incentive plan would provide for the reimbursement in total of net variable costs in the developmental centers without adjustment or offsets.

(a) For each rate period, the net variable cost will be calculated based on the number of reduced beds planned for that rate period. 100 percent reimbursement of the net variable cost will be allowed for that rate period.

(b) Under this incentive plan eligible costs will be limited to personal service costs including fringe benefits and overhead and other than personal service costs excluding capital costs.

(c) To determine the capital cost portion of the rate, OMRDD shall review the component relating to capital costs for substantial material changes and if said changes conform to the requirements of paragraphs (f)(1) and (3) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary, make corresponding adjustments in computing the subsequent period rate.

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[(v)] **(vi)** The computation of the rate resulting from the application of this paragraph can also be represented by the following formula:

- (a)  $\text{trended reimbursable operating costs} + \text{untrended reimbursable operating costs} + \text{reimbursable capital costs} = \text{total reimbursable costs.}$
- (b)  $\text{total reimbursable costs} / \text{units of service} = \text{the rate.}$

[(vi)] **(vii)** If OMRDD is unable to compute a rate for a newly certified facility, it may establish an interim rate which shall be the regional average for other facilities.

- (a) OMRDD shall replace the interim rate retroactively to the starting date of such interim rate by a rate developed from the initial budget report submitted by the facility.
- (b) The rate developed from the initial budget report shall be subject to all the requirements of this section, and shall be effective for the remainder of the then current rate period.

[(vii)] **(viii)** Since July 1, 1996, providers have been responsible for any necessary transportation to and from physician, dentist, and other clinical services, and any other transportation appropriate to the consumer's participation in community-based out of residence activities planned for or sponsored by the facility. Nothing herein shall be interpreted as precluding the accessing of separate Medicaid claiming for emergency/nonemergency ambulance services (as defined in 18 NYCRR 505.10) necessitated by the consumer's medical condition.

[(viii)] **(ix)** (a) To encourage the closure of developmental centers, the commissioner will consider proposals to allow the variable costs associated with the closed facility or facilities to become part of the operating expenses of new or existing state operated under 31 bed facilities. The commissioner will allow a reasonable incentive plan for the reimbursement of the increased costs in the state operated under 31 bed facilities if it is coupled with the closure of a developmental center. An incentive plan would provide for the reimbursement in total of increased costs in the state operated under 31 bed facilities without adjustment or offsets.

- (i) 100 percent reimbursement of the increased cost for at least one full rate period, but less than two full rate periods.

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- (ii) 75 percent reimbursement of the increased cost for the second full rate period.
  - (iii) 50 percent reimbursement of the increased cost for the third full rate period.
  - (iv) 25 percent reimbursement of the increase cost for the fourth full rate period.
- (b) Costs to be eligible for this incentive plan will include but not be limited to direct care, support and clinical personal service and fringe benefit amounts for employees whose most recent prior employment was at a closed or scheduled to close developmental center.
- (i) In order to have the cost of former developmental center employees included in the incentive plan, the state operated facility applying for a rate adjustment must hire such employee within twelve months of the official closing date of the developmental center.
  - (ii) Salaries and fringe benefit amounts paid to eligible employees by the facility cannot exceed the average salary and fringe benefit amount paid to comparable employees currently on that facility's payroll.
- (c) Incentive plan applications from provider shall be made in writing to the commissioner.
- (i) The application shall identify the employees, their job titles, salary levels, date hired and B/DDSO.

[(ix)] **(x)** To accelerate the closure and to encourage a reduction in the size of developmental centers, the commissioner will consider proposals to allow the variable costs associated with a developmental center to become part of the operating expenses of new and existing state operated under 31 bed facilities. The variable costs associated with the developmental center will be allowed for the transition which is the period beginning on the date an official announcement to close a facility or facilities and ending on the date of actual closure. Also variable costs associated with the planned conversion of beds which is at least 10 percent change in the facility census will be allowed. The commissioner will allow a reasonable incentive for the reimbursement of the increased costs in the state operated under 31 bed facilities during the transition and/or conversion period. An incentive plan would provide for the reimbursement in total of increased costs in the state operated under 31 bed facilities without adjustments or offsets.

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- (a) The commissioner will allow the following reimbursement for approved proposals:
- (i) 75 percent reimbursement of the increased costs incurred during the transitional closure period. On the effective date of closure, reimbursement of increased costs will be considered under subsection (c)(3)(viii).
  - (ii) 75 percent reimbursement of the increased costs incurred during the conversion period. The conversion period will be for at least one full rate period but less than two full rate periods. If during the conversion period, an official announcement of closure occurs, the reimbursement of increased costs may be considered under (c)(3)(ix)(a)(i).
- (b) Costs to be eligible for this incentive plan will include but not be limited to direct care, support and clinical personal service and fringe benefit amounts for employees whose most recent prior employment was at a developmental center.
- (i) In order to have the cost of former developmental center's employee included in the incentive plan, the facility applying for a rate adjustment must hire such employee during the transitional and conversion periods.
  - (ii) Salaries and fringe benefit amounts paid to eligible employees by the facility cannot exceed the average salary and fringe benefit amount paid to comparable employees currently on that facility's payroll.
- (c) Incentive plan applications from the provider shall be filed in accordance with (c)(3)(viii)(c).
- (4) Computation of the base period rate.
- (i) For each facility the commissioner shall establish rates in accordance with the certified capacity as stated in a facility's provider agreement.
  - (ii) Base period rates for over thirty bed facilities and developmental centers shall be computed on the basis of a full 12-month cost report submitted by the provider for the 12-month period beginning 24 months prior to the effective date of the base period, and subject to the cost category screens described herein. For a newly certified over thirty bed facility, OMRDD

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shall use budget data, as submitted pursuant to NYCRR subpart 635-4 or 681.12 (which ever is applicable).

(iii) The [initial] base period rate for under thirty-one bed Region II and III non-state operated facilities shall be computed on the basis of a full twelve month cost report submitted by the provider for the twelve month period beginning January 1, [1994] **1999 and adjusted in accordance with subparagraph (3)(ii) of this subdivision**. The [initial] base period rate for under thirty-one bed Region I non-state operated facilities shall be computed on the basis of a full twelve month cost report submitted by the provider for the twelve month period beginning July 1, [1994] **1999 and adjusted in accordance with subparagraph (3)(ii) of this subdivision**. For state operated facilities of under thirty-one beds, regardless of region, the initial base period rate shall be computed on the basis of a full twelve month cost report submitted by the provider for the twelve-month period beginning April 1, [1994] **1999 and adjusted in accordance with subparagraph (3)(ii) of this subdivision**. Thereafter, the base period rates for under thirty-one bed facilities shall be computed on the basis of a full twelve month cost report submitted by the provider for the twelve month period beginning [36] **48** months prior to the effective date of the base period. [However, there shall be no base period rate for the rate periods beginning January 1, 2002, April 1, 2002 and July 1, 2002.] For a newly certified under thirty-one bed facility, OMRDD shall use the budget data submitted pursuant to NYCRR subpart 635-4 or 681.12 (which ever is applicable).

(iv) For a newly certified facility, the initial base period rate shall be determined pursuant to subparagraph (vii) of this paragraph. For under thirty-one bed facilities the units of service are determined by multiplying the certified capacity of the facility by 365 days. For over thirty bed facilities, units of service are the certified capacity of the facility multiplied by 365 days multiplied by 99 percent. A facility's submitted budget costs may be adjusted based on a comparison to the actual costs of other existing facilities operated by the provider in order to determine the costs of an efficient and economic operation. If the provider does not operate other facilities, the submitted budget costs may be adjusted based on a comparison to the average costs of other facilities in the same region.

(v) For facilities which are not newly certified facilities, the initial base period rate shall be determined pursuant to subparagraph (vii) of this paragraph. For under thirty-one bed facilities the units of service are determined by multiplying the certified capacity of the facility by 365 days. For over thirty bed facilities, units of service are the higher of the certified capacity of the facility multiplied by 365 days multiplied by 99 percent, or the actual reported units of service.

(vi) As appropriate, OMRDD shall apply trend factors to each facility's reimbursable operating costs, except for education and related services.

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(vii) The computation of the rate resulting from the application of this paragraph can also be represented by the following formula:

(a)  $\text{trended reimbursable operating costs} + \text{untrended reimbursable operating costs} + \text{reimbursable capital costs} = \text{total reimbursable costs.}$

(b)  $\text{total reimbursable costs} / \text{units of service} = \text{the rate.}$

(viii) For [under thirty-one bed] **all** facilities there shall be a day [treatment] **program services** add-on [such] **so** that facilities which have day [treatment] **program services** included in their [operating costs] **rate shall be** reimbursed [in their base period rate. For day treatment services, a facility shall be reimbursed at a varying funding level, for a maximum of 225 days per year. The facility will be reimbursed at the lower of either the actual costs per the cost report (or for budget costs for newly certified facilities) or the calculated per diem fee for day treatment services pursuant to 14 NYCRR section 690.7 of this Title in effect for the appropriate fee period.] **as follows for these services. The add-on shall reflect service needs as well as efficiency and economy of operation.**

[(ix) For all facilities there shall be a day services add-on such that facilities which have the following day services included in their operating costs shall be reimbursed as follows for these services.]

(a) For sheltered workshop services, effective July 1, 1995, the facility will receive a reimbursable cost of \$9,899 per annum for each program participant. For program participants to whom the conditions set forth in subparagraph [(x)](ix) of this paragraph apply, the facility will receive a reimbursable cost of \$9,499 per annum for each program participant.

(b) For day training [services] **programs**, effective July 1, 1995, the facility will receive a reimbursable cost of \$11,033 per annum for each program participant. For program participants to whom the conditions set forth in subparagraph [(x)](ix) of this paragraph apply, the facility will receive a reimbursable cost of \$10,633 per annum for each program participant.

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(c) [Upon an agency's application] If an agency applies to OMRDD prior to January 1, 2003 and for participants receiving services in day training facilities where the Developmental Disability Profile average score for the site exceeds 348 for the adaptive score and exceeds 10 for the health score, the amount of [reimbursement] the add-on shall be determined by a budget review. The amount of [reimbursement] the add-on received by the ICF/DD for such day training services shall reflect individual service needs as well as efficiency and economy of service provision. Effective January 1, 2003, for any facility to which this subclause applies the add-on will be equal to the reimbursement that was in the facility's rate on December 31, 2002, and that was applicable to day training services described in this subclause.

(d) The costs of day program services delivered in a certified Day treatment facility (see Part 690 of 14 NYCRR) may not be included as an add-on to the ICF/DD rate.

(e) Effective January 1, 2003, a provider may request that a day services add-on be included in the facility's rate. The day program services add-on for all day program services shall be either the day program services reimbursement included in the rate on December 31, 2002 and adjusted for actual service delivery; or the lower of:

(1) the actual costs per the cost report, or

(2) the budget costs

(3) The costs in subclauses (1) and (2) of this clause are subject to a desk audit. Administrative review of these desk audits shall be in accordance with subdivision 635-6(h) if 14 NYCRR.

[(c)] (f) Effective June 1, 1995, the facility will be reimbursed for education and related services in accordance with Title 8 NYCRR. These costs shall not be trended.

[(x)](ix) Effective July 1, 1997 an under thirty-one bed facility may submit to the commissioner a request for a transportation add-on for transportation of

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persons to and from an outpatient service certified pursuant to Article 28 of the Public Health Law for certain persons if:

- (a) in order to meet a person=s active treatment needs the person=s Individual Program Plan requires a day service (comprising regular attendance at a sheltered workshop or a day training service) in combination with visits to the outpatient service described above, and
- (b) prior to July 1, 1996, transportation to and from the outpatient service was not included in the rate for the operator of the outpatient service, and
- (c) prior to July 1, 1996, the rate approved by the local social services district was billed separately by a transportation vendor for transportation to and from the outpatient service, and
- (d) the vendor ceased billing for transportation of persons residing in the facility to and from the outpatient service.

[(xi)](x) The transportation add-on shall be a reimbursable cost added to a facility=s rate subject to the conditions set forth in subparagraph [(x)](ix) of this paragraph. The transportation add-on shall be calculated using payment/rate data based on local social service district approved Medicaid payment rates made to transportation vendors as of June 30, 1996. A weighted transportation average shall be calculated for each facility by dividing the aggregate transportation payments by the aggregate day service transportation round trips for all persons described in subparagraph [(x)](ix) of this paragraph.

- (a) The weighted transportation average for each facility shall be ranked among all day treatment facilities state wide pursuant to the methodology for calculating the transportation component add-on for day treatment facilities described in NYCRR Part 690 subclauses 690.7 (e)(3)(vii)(a)(1) through and including (a)(3).
- (b) The modified weighted transportation average shall be multiplied by the total to and from day service transportation units of service to determine reimbursable transportation costs.

(5) Computation of the subsequent period rate.

(i) The reimbursable operating costs contained in the subsequent period rates shall be computed as follows. OMRDD shall determine the total

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reimbursable operating costs (with the exception of education and related service costs, sheltered workshop services, day training services) included in the payment rate in effect on December 31, March 31 or June 30 of the immediately preceding rate period applicable to that facility. The dollars for sheltered workshop and day training services shall be revised based upon the number of individuals participating in the program. The reimbursable operating costs plus any revised sheltered work and day training costs will be increased by the trend factor described in subdivision (g) of this section and may be adjusted for appropriate appeals. Education and related services will be updated in accordance with clause (4)(ix)(c) (f) of this subdivision. OMRDD will determine the capital cost portion of the subsequent period rate by reviewing the component relating to capital costs for substantial material changes. If such changes conform to the requirements of paragraphs (f)(1) and (3) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary, OMRDD will make corresponding adjustments in computing the subsequent period rate.

- (ii) The computation of the rate resulting from the application of this paragraph can also be represented by the following formula:
  - (a) trended reimbursable operating costs + untrended reimbursable operating costs + reimbursable capital costs = total reimbursable costs.
  - (b) total reimbursable costs / units of service = the rate.
- (iii) For a newly certified facility which begins to provide services that fall within a subsequent period, the initial rate shall be calculated as though it were a base period rate.

(d) Cost category screens and reimbursement for under thirty-one bed facilities.

In order to determine the reimbursable operating costs to be included in the rate calculation, the following screens (i.e., the maximum amount that will be allowed for a specific item or group of items) will be used. The regional screens corresponding to the actual geographic location of the facility will be applied.

- (1) Administration screens and reimbursement.
  - (i) Screens.
    - (a) Administrative screen values shall be equal to the sum of the total reimbursable administrative costs and the total reimbursable administrative fringe benefits, less the value of the efficiency adjustment, included in the rate effective on the last day of the

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immediately preceding rate period. This amount shall be detrended to the base period.

- (b) For facilities without a screen as determined in clause (a) of this subparagraph, operated by a provider which does operate other facilities, an agency administrative percentage based on the current reimbursement of those other facilities shall be applied.
- (c) For facilities without a screen as determined in clauses (a) and (b) of this subparagraph, operated by a provider which operates other OMRDD certified residential programs, an agency administrative percentage based on the current reimbursement of the other OMRDD certified residential programs shall be applied.
- (d) For facilities without a screen as determined in clauses (a) - (c) of this subparagraph, operated by a provider which does not operate any other OMRDD certified residential programs, a regional average administrative percentage based on the current reimbursement of facilities operated by other providers shall be applied.
- (e) For facilities without a screen value as determined per clause (a) of this subparagraph, the administrative screen value shall be equal to the percentages derived from clause (b), (c) or (d) of this paragraph times the reimbursable operating costs other than administration. This value shall be detrended to the base year.
- (ii) Reimbursable administration costs shall be the lesser of administrative base year costs/ budget costs, or the screen value as determined in subparagraph (i) of this paragraph.

## (2) Direct care screens and reimbursement.

- (i) Screen. The direct care screen value shall be the direct care FTEs multiplied by the regional salary.
- (a) Direct care FTEs shall be calculated utilizing the facility specific disability increment plus bed size increment. The term disability increment shall mean the process of developing facility specific direct care FTEs based upon aggregate consumer disability characteristics as described in 14 NYCRR subdivision 690.7 (g) [of this Title] and reported on the Developmental Disabilities Profile (DDP). The disability increment methodology will only be calculated if at least 50 percent of the DDP scores are available. If less than 50 percent of the DDP scores are

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available, the direct care FTEs calculated shall be based upon bed size increment alone. The disability increment using the DDP scores is calculated as follows: 0.063 FTEs times the facility mean direct care score plus .008 FTEs times the facility mean behavior score plus 0.062 FTEs times the facility standard deviation direct care score minus 0.019 FTEs times the facility standard deviation behavior score. The direct score is computed for each consumer from the DDP adaptive and health/medical scores as follows: 7.962 plus 0.156 times the adaptive score plus 1.611 times the health/medical score. The bed size increments are as follows:

Bed size	Bed size increment
four	5.700
five	8.310
six	6.448
seven	7.123
eight	8.294
nine	9.171
ten	10.957
eleven	10.939
twelve	12.746
thirteen	9.277
fourteen	15.154
fifteen	10.507
sixteen	14.530
seventeen	16.987
eighteen	18.501
nineteen	18.751
twenty	15.115
twenty-one	20.515
twenty-two	24.873
twenty-three	19.688
twenty-four	22.935
twenty-five	24.043
twenty-six	30.361
twenty-seven	31.325
twenty-eight	32.265
twenty-nine	33.205
thirty	34.145

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(b) Direct care regional salaries.

Region

I	\$[26,024] <u>\$29,375</u>
II	[24,627] <u>29,522</u>
III	[21,085] <u>25,005</u>

Note: The above values are in base year dollars.

(ii) Reimbursable direct care costs shall be the lesser of the base year costs/budget costs or the screen values established by subparagraph (i) of this paragraph.

(3) Support personal service screens and reimbursement.

(i) Screen. The support screen value shall be the support FTEs multiplied by the regional salary.

(a) Support FTE screen values for budget-based facilities:

Bed size	Support FTE value
4	[0.59] <u>0.55</u>
5	[0.74] <u>0.71</u>
6	[0.89] <u>0.87</u>
7	[1.04] <u>1.03</u>
8	1.19
9	[1.34] <u>1.35</u>
10	[1.49] <u>1.50</u>
11	[1.64] <u>1.66</u>
12	[1.79] <u>1.82</u>
13	[1.94] <u>1.98</u>
14	[2.09] <u>2.14</u>
15	[2.24] <u>2.30</u>
16	[2.39] <u>2.46</u>
17	[2.54] <u>2.61</u>
18	[2.69] <u>2.77</u>
19	[2.84] <u>2.93</u>
20	[2.99] <u>3.09</u>
21	[3.14] <u>3.25</u>
22	[3.29] <u>3.41</u>
23	[3.44] <u>3.56</u>

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24	[3.591] <u>3.72</u>
25	[3.7,41] <u>3.88</u>
26	[3.891] <u>4.04</u>
27	[4.041] <u>4.20</u>
28	[4.191] <u>4.36</u>
29	[4.341] <u>4.52</u>
30	[4.491] <u>4.67</u>

(b) Support FTE screen values for cost-based facilities are based on the base year cost report.

(c) Support regional salaries.

Region

I	\$(26,024] <u>29,375</u>
II	[24,627] <u>29,522</u>
III	[21,085] <u>25,005</u>

Note: The above values are in base year dollars.

(ii) Reimbursable support personal service costs shall be the lesser of the base year costs/budget costs, or the screen values established in subparagraph (i) of this paragraph.

(4) Clinical screens and reimbursement.

(i) For facilities which are not newly certified, the clinical screen shall be the [value contained in the base year cost report] the appropriate clinical regional salary multiplied by the base year cost report clinical FTEs. Clinical regional salaries are:

<u>Region</u>	
<u>I</u>	<u>\$56,510</u>
<u>II</u>	<u>53,584</u>
<u>III</u>	<u>40,414</u>

Note: The above values are in base year dollars.

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(ii) For newly certified facilities, that have a rate effective on the last day of the immediately preceding rate period, the [clinical screen will be equal to the clinical costs] reimbursable clinical costs will be the clinical FTEs approved and reimbursed in the rate effective on the last day of the immediately preceding rate period multiplied by the lesser of:

(a) the clinical average salary reimbursed in the rate on the last day of the immediately preceding rate period detrended to the base year; or

(b) the appropriate clinical regional salary listed in subparagraph ( i ) of this paragraph.

(iii) For newly certified facilities, that do not have a rate effective on the last day of the immediately preceding rate period, [the clinical screen will be based upon budgeted FTEs] OMRDD will consider budgeted FTEs and average salaries, reviewed and adjusted if necessary through a desk audit process [and multiplied by the base year average reimbursed clinical salary of the other facilities operated by the provider. If the provider does not operate any other facilities then a base year regional average reimbursed clinical salary will be utilized.] The reimbursable clinical costs shall be the desk-audited budgeted clinical FTEs multiplied by the lesser of:

(a) the desk audited budgeted clinical average salary, detrended to the base year; or

(b) the appropriate regional clinical salary listed in subparagraph ( i ) of this paragraph.

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(iv) For facilities which are not newly certified the reimbursable clinical costs shall be the [base year clinical costs. For newly certified facilities the reimbursable costs shall be the lesser of the clinical budget year costs or the screen values established in subparagraph (ii) or (iii) of this paragraph.] base year cost report clinical FTEs multiplied by the lesser of:

(a) the base year cost report clinical average salary; or

(b) The appropriate clinical regional clinical salary listed in subparagraph (i) of this paragraph.

(5) Fringe benefit screens and reimbursement.

(i) For every new rate cycle, OMRDD shall compute a facility-specific fringe benefit percentage. This percentage shall be determined by summing the direct care, clinical and support fringe benefit costs from the base year budget or cost report and dividing this sum by the sum of direct care, clinical and support personal service costs (exclusive of contracted personal service) from the base year budget or cost report.

(ii) For newly certified facilities, that have a rate effective on the last day of the immediately preceding rate period, the fringe benefit percentage screen shall equal the fringe benefit percentage contained in the rate effective on the last day of the immediately preceding rate period.

(iii) For newly certified facilities, that do not have a rate effective on the last day of the immediately preceding rate period, the fringe benefit percentage screen (as calculated in subparagraph (i) above) shall equal the average percentage reimbursed to existing facilities currently operated by the provider. If there are no existing facilities, then the fringe benefit percentage screen shall equal the average reimbursed fringe benefit percentage of any other programs operated by the provider. If the provider does not operate any other programs, then the fringe benefit percentage screen shall equal the regional average percentage reimbursed to other facilities.

(iv) Reimbursable fringe benefit costs shall be equal to the computed fringe benefit percent established in subparagraphs (i), (ii) or (iii) of this paragraph multiplied by the reimbursable direct care, clinical and support personal service dollars, exclusive of contracted personal service.

(6) Support OTPS (other than personal service) screens and reimbursement.

(i) Capacity	Region I	Region II	Region III
4	51,314	41,999	39,150
5	64,142	52,499	48,938
6	76,970	62,999	58,725
7	89,799	73,499	68,513
8	102,627	83,999	78,300

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9	115,456	94,498	88,088
10	128,284	104,998	97,875
11	141,112	115,498	107,663
12	153,941	125,998	117,450
13	166,769	136,498	127,238
14	179,598	146,998	137,025
15	192,426	157,497	146,813
16	205,254	167,997	156,600
17	218,083	178,497	166,388
18	230,911	188,997	176,175
19	243,740	199,497	185,963
20	256,568	209,997	195,570
21	269,396	220,496	205,538
22	282,225	230,996	215,325
23	295,053	241,496	225,113
24	307,882	251,996	234,900
25	320,710	262,496	244,688
26	333,538	272,996	254,475
27	346,367	283,495	264,263
28	359,195	293,995	274,050
29	372,024	304,495	283,838
30	384,852	314,995	293,625]

(i) The facility's support OTPS screen is determined by multiplying the certified capacity by the appropriate regional per bed value.

(ii) Support OTPS regional per bed values:

Region	
<u>I</u>	<u>\$16,097</u>
<u>II</u>	<u>13,085</u>
<u>III</u>	<u>16,418</u>

Note: The above values are in base year dollars.

[(ii)](iii) Reimbursable support OTPS costs shall be the lesser of the base year costs / budget costs, or the screen values established in subparagraph (i) of this paragraph.

(7) Utility costs will not be included within the support OTPS screen. The reimbursable utility costs shall be the base year costs or budget costs.

[(8) OMRDD shall include in reimbursable costs a regional FTE add-on calculated by multiplying FTEs established per subparagraph (2)(i)(a) of this paragraph by the following dollar amounts:

Region One	\$624.00
Region Two	\$623.35
Region Three	\$556.87

Note: The above values are in base year dollars.]

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(e) Cost Category Screens and reimbursement for over thirty bed facilities. In order to determine the reimbursable operating costs to be included in the rate calculation, the following screens (i.e., the maximum amount that will be allowed for a specific item or group of items) will be used.

(1) Direct care, mid-level supervision, and clinical personal service cost category screens:

(i) For every new rate cycle, OMRDD shall develop values by applying a maximum statewide salary amount to a facility's applicable consumer specific staffing standards. Refer to paragraphs (5)-(8) of this subdivision.

(ii) These standards shall reflect the severity of disabilities of the population residing at the facility as determined by the procedures outlined in paragraphs (5)-(7) of this subdivision; the number of beds in the facility; whether or not a facility provides on site day program services; and the persons the facility provides services to ( i.e., adults, children or both).

(iii) For any facility which elected to participate in the salary enhancement plan as evidenced by adoption of a resolution of its governing body, effective on the later of October 1, 1987, or the date of adoption of such resolution, the direct care/support reimbursement will be adjusted to reflect the obligation to pay salary levels established by adoption of the resolution referred to in this subclause. In absence of such an election, the standard shall be determined by the facility's actual salary amount based upon the budget or cost report used to establish the rate being adjusted or calculated.

(2) Administrative and support cost category screens:

(i) OMRDD shall develop values for every new rate cycle by application of a statewide maximum allowable cost.

(ii) The personal service costs shall be determined by applying a maximum statewide salary amount to the allowable staffing level contained in this subdivision.

(iii) For any facility which elected to participate in the salary enhancement plan as evidenced by adoption of a resolution of its governing body, effective on the later of October 1, 1987, or the date of adoption of such resolution, the direct care/support reimbursement will be adjusted to reflect the obligation to pay salary levels established by adoption of the resolution referred to in this subclause. In the absence of such an election, the standard shall be

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determined by the facility's actual salary amount based upon the budget or cost report used to establish the rate being adjusted or calculated.

(3) Fringe benefit cost category screens:

- (i) For every new rate cycle, OMRDD shall compute a facility- specific fringe benefit percentage. This percentage shall be determined by computing the total fringe benefit cost from the base year budget or cost report and dividing this total by the total personal service cost (exclusive of contracted personal service) from the base year budget or cost report. For every rate cycle after April 1, 1984, this percentage shall be the lower of the previous rate cycle's cost-based fringe benefit percentage plus one percent or a new percentage computed in accordance with the immediately preceding sentence. If a facility's previous rate is based upon a budget, it is not subject to the aforementioned one-percent fringe benefit limitation.
- (ii) To determine the fringe benefit component of the rate, the facility- specific fringe benefit percentage shall be multiplied by the total reimbursable personal service dollars exclusive of contracted personal services.
- (iii) For newly certified facilities, the fringe benefit percentage allowed shall not exceed the average allowed for existing facilities (regardless of size) currently operated by the provider. If there are no existing facilities, then the fringe benefit percentage allowed shall not exceed the fringe benefit percentage of any other programs operated by the provider. If the provider does not operate any other programs, then the fringe benefit percentage allowed shall not exceed the regional average for other facilities.
- (iv) Any increase in the fringe benefit percentage due to Federal or State laws, rules or regulations shall not be subject to the percent increase limitation described in subparagraph (i) of this paragraph.
- (v) If a newly certified facility whose base period rate was determined from total reimbursable budget costs, submits a cost report for the subsequent period in accordance with 14 NYCRR subpart 635-4 [of this Title], a new fringe benefit percentage shall be computed by dividing these costs by the total personal service costs (exclusive of contracted services) as submitted in the new cost report. This percentage shall be subject to the limitations of subparagraphs (i) and (ii) of this paragraph.

(4) Other than Personal Service (OTPS) and Overhead shall be combined into one cost category screen.

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- (i) The Other than Personal Service cost category screen will be based on a per bed amount effective at the beginning of each new rate cycle (see paragraph (8) of this subdivision.)
- (ii) The Overhead cost category screen will be a percentage of reimbursable personal service and fringe benefits (see paragraph (8) of this subdivision). This screen will be compared to reported cost or budget costs (agency administration, personal service, OTPS, fringe benefits and capital costs) to determine reimbursable costs.
- (iii) Costs associated with transportation to and from physician, dentist and other clinical services shall be included in the Other than Personal Service screen and subject to the limitations contained therein.

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- (5) Over thirty bed facility staffing standards, algorithm and screens. FTE factors to determine staff allocations for consumers with differing day programs, who reside in over thirty bed facilities.

Current Willow-brook ratios	Ratios with offsets for adults with outside day program	Ratios with offsets for children with outside day program	On site day program consumer requiring 1:1	31-bed facility children on-site day program
Direct Care 1:4 0.9917 FTE 1:6 0.7083 FTE 1:16 0.3541 FTE	Direct Care 1:4 0.8889 FTE 1:6 0.6399 FTE 1:16 0.3285 FTE	Direct Care 1:4 0.9442 FTE	Direct Care 3.5417 FTE	Direct Care 0.9917 1:4
Mid-level supervision 0.1771 FTE	Mid-level supervision 0.1599 FTE	Mid-level supervision 0.1692 FTE	Mid-level supervision 0.1771 FTE	Mid-level supervision 0.1771 FTE
General clinical 0.3333 FTE	General clinical 0.2934 FTE	General clinical 0.3147 FTE	General clinical See below	General clinical 0.4878 FTE

60+ bed facility children on-site day program	100+ bed facility children on-site day program	31-bed facility adults on-site day program	60-bed facility adults on-site day program	100+ bed facility adults on-site day program
Direct Care 1:4 0.9917 FTE	Direct Care 1:4 0.9917 FTE	Direct Care 1:4 0.9917 FTE 1:6 0.7083 FTE 1:16 0.3541 FTE	Direct Care 1:4 0.9917 FTE 1:6 0.7083 FTE 1:16 0.3541 FTE	Direct Care 1:4 0.9917 FTE 1:6 0.7083 FTE 1:16 0.3541 FTE
Mid-level supervision 0.1771 FTE	Mid-level supervision 0.1771 FTE	Mid-level supervision 0.1771 FTE	Mid-level supervision 0.1771 FTE	Mid-level supervision 0.1771 FTE
General clinical 0.4350 FTE	General clinical 0.3883 FTE	General clinical 0.4046 FTE	General clinical 0.3651 FTE	General clinical 0.3518 FTE

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- (6) For the purposes of developing an economy of scale, the following FTE offsets shall be applied against the clinical ratios listed in paragraph (5) of this subdivision:
- (i) For children, bed sizes 32-59, a straight deduction of 0.00182 will be computed per 1-bed increase from the 0.4878 at 31 beds.
  - (ii) For children, bed sizes 61-99, a straight deduction of 0.00119 will be computed per 1-bed increase from the 0.4350 at 60 beds.
  - (iii) For adults, bed sizes 32-59, a straight deduction of 0.00136 will be computed per 1-bed increase from 0.4046 at 31 beds.
  - (iv) For adults, bed sizes 61-99, a straight deduction of 0.00034 will be computed per 1-bed increase from 0.3651 at 60 beds.
- (7) An assessment of consumer level of disability for the purposes of designating direct care staffing levels, as listed in paragraph (5) of this subdivision, shall be completed utilizing the following criteria.

Direct Care Shift	Ratio	Factor	Description
Day or Evening	1:4	0.25000	1) All children age 21 and under 2) All nonambulatory consumers nonambulatory or wheelchair only) 3) All multiply handicapped consumers (blind or deaf or tube- fed) 4) All nonself-preserving consumers
	1:16	0.06250	All consumers over age 22 who: 1) walk freely 2) have a mental level moderate or above 3) are toilet-trained 4) do not need help eating or dressing 5) have no serious behavior problems 6) do not have any mild behavior problems in the following categories: a) assaults others b) self-abusive c) destroys property d) runs away

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7) have some speech and comprehension

1:6 0.16666 All others not in above categories

Night 1:12 0.08333 All consumers

(8) Cost center screens for over thirty bed facilities.

(i) From July 1 to June 30, the cost center screens shall be:

(a) Salaries.

Cost area

Administration and support	\$21,751
Direct care and mid-level supervision	20,814
Clinical	34,824

(b) Other cost center screens.

Cost area

OTPS/bed	\$ 9,190
Overhead	7.29%
Administration and support FTE	0.6284/bed

(ii) From January 1 to December 31 the cost center screens shall be:

(a) Salaries.

Cost area

Administration and support	\$19,413
Direct care and mid-level supervision	19,956
Clinical	31,931

(b) Other cost center screens.

Cost area

OTPS/bed	\$ 9,180
Overhead	6.76%
Administration and support FTE	0.56/bed

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(vi) April 1 to March 31 the cost center screens shall be:

(a) Salaries

Administration and Support	\$21,560
Direct Care and Mid-level Supervision	20,643
Clinical	34,495

(b) Other Cost Center Screens

Cost Area

OTPS/Bed	\$9,121
Overhead	6.34%
Administration and Support FTE	.6288 FTE/Bed

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(f) Allowable costs. To be considered allowable, costs must be properly chargeable to necessary consumer care rendered in accordance with the requirements of this Part.

(1) Allowable costs (general).

(i) Except where specific rules concerning allowability of costs are stated herein, or in subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, or subdivision (k) Glossary, the Medicare Provider Reimbursement Manual, commonly referred to as HIM-15, shall be used to determine the allowability of costs. HIM-15 is published by the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA) and is available from:

Health Care Financing Administration  
Division of Publications Management-SSL-12-15  
7500 Security Boulevard  
Baltimore, MD 21244-1850

It may be reviewed in person during regular business hours at the NYS Department of State, 41 State Street, Albany, NY 12207; or, by appointment, at the NYS Office of Mental Retardation and Developmental Disabilities, Division of Revenue Management, 44 Holland Avenue, Albany, NY 12229-0001.

(ii) Where [specific] rules stated herein, in subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, in subdivision (k) Glossary or in HIM-15, are silent concerning the allowability of costs, the commissioner shall determine allowability of costs based on reasonableness and relationship to consumer care and generally accepted accounting principles.

(iii) Expenses or portions of expenses reported by a facility that are not reasonably related to the efficient and economical provision of care in accordance with the requirements of this Part, because of either the nature or amount of the item, shall be not allowed.

(iv) Costs which are not properly related to consumer care or treatment, and which principally afford diversion, entertainment or amusement to owners, operators or employees of the facility, shall not be allowed.

(v) The OMRDD shall reduce a facility's base year costs / budget costs by the costs of such services and activities that are not chargeable to the care of the consumers in accordance with this subdivision.

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- (a) In the event that the commissioner determines that it is not practical to establish the costs of such services and activities, the income derived therefrom shall be substituted as the basis for reductions of the facility's reported or estimated costs.
- (b) Examples of sources of such income include, but are not limited to:
  - (1) supplies and drugs sold by the facility for use by nonresidents;
  - (2) telephone and telegraph services for which a charge is made;
  - (3) discount on purchases;
  - (4) employees' rental of living quarters;
  - (5) cafeterias;
  - (6) meals provided to staff or a consumer's guests for which there is a charge;
  - (7) operating parking facilities for community convenience; and
  - (8) lease of office and other space by concessionaires providing services not related to intermediate care facility services.
- (vi) Costs for any interest expense related to funding expenses in excess of an approved rate, or penalty imposed by governmental agencies or courts and the costs of insurance policies obtained solely to insure against such penalty, shall not be allowed. OMRDD will not pay interest on the final dollar settlement resulting from the retrospective impact of the rate appeals.
- (vii) Costs of contributions or other payments to political parties, candidates or organizations shall not be allowed.
- [(viii) Costs of related organizations, other than costs incurred pursuant to a lease, rent or purchase of real property, may be an allowable cost subject to the following:

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- (a) A related organization means any entity of which the facility is in control or by which the facility is controlled including the organizations and persons listed in clauses (3)(iii)(c)-(f) of this subdivision, either directly or indirectly, or where an association of common interest exists in an entity which supplies goods and/or services to the facility.
- (b) The costs of goods and/or services furnished to a facility, within the course of normal business operations, by a related organization, are allowable at the cost to the related organization, or the market price of comparable goods and/or services available in the facility's region, whichever is lower.]
- [(ix)] (viii) Restricted funds are funds expended by the facility, which include grants, gifts, and income from endowments, whether cash or otherwise, which must be used only for a specific purpose as designated by the donor or grant instrument. Except as provided for in [clauses (3)(iv)(d) and (e)] subparagraphs (3)(iii) and (iv) of this subdivision, restricted funds are to be deducted from the designated costs when determining allowable costs. The commissioner may waive the provisions of this subparagraph at his discretion only in those instances where the provider makes a reasonable showing that the imposition of the requirements of this subparagraph would cause undue financial harm to the existence of the facility.
- [(x)] (ix) Only that portion of the dues paid to any professional association which has been demonstrated to be attributable to expenditures other than for lobbying or political contributions shall be allowed.
- [(xi)] (x) A monetary value assigned to services provided by a religious order for services rendered to an owner and operator of a facility shall be considered allowable subject to review by OMRDD for reasonableness.
- [(xii)] (xi) Funded depreciation.
  - (a) Applicability. This subparagraph shall apply to all facilities except those governed by [clause (3)(iv)(d) or (e)] subparagraphs (3) (iii) or (iv) of this subdivision and those for which the provider is receiving or has a commitment to receive HUD funding. This section shall apply to facilities which were governed by [clause (3) iv)(d) or (e)] subparagraphs (3)(iii) or (iv), but which are no longer governed by either such section because the provider has repaid the entire principal owed on the real property of the facility.

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- (b) Effective April 1, 1986, for any rate period during which the reimbursement attributable to depreciation on a facility's real property, excluding equipment, exceeds the provider's principal repayment obligations on indebtedness attributable to such real property, such provider shall fund depreciation by depositing such difference in an interest-bearing checking account or other secure investment. If the provider operates more than one facility governed by this paragraph, the provider may maintain one funded depreciation account for two or more facilities. The provider shall not commingle such funded depreciation accounts with other monies of the provider. The provider shall not be required to fund depreciation attributable to the provider's equity in such real property. The provider may expend the funds in such account, including accrued interest, to retire all or a portion of the indebtedness attributable to such real property, or for building improvements and/or fixed equipment necessary to the facility.
- (c) OMRDD will not reimburse interest expense incurred to meet funded depreciation, pursuant to this subparagraph and [clauses (3)(iv)(d) and (e)] subparagraphs (3) (iii) and (iv) of this subdivision.

(2) Allowable costs (operating).

- (i) Interest on working capital indebtedness in accordance with standards listed in [subparagraph (3)(vii) of this] subdivision (j) General Rules for Capital-Costs and Costs of Related Party Transactions and subdivision (k) Glossary and subject to the limitations of paragraphs (d)(1) or (e)(4) of this section will be considered allowable. In the event that a loan is not in accordance with the standards listed above, then the approval of the commissioner is required.
- (ii) Effective April 16, 1992, costs incurred as a result of the provider of services assessment charged pursuant to section 43.04 of the Mental Hygiene Law in the amount of 2.4 percent of the 3 percent assessment charged on cash receipts shall be included in the rate.
- (iii) Effective April 4, 1996, costs in excess of 0.6 percent incurred as a result of the provider of services assessment charged on cash receipts pursuant to section 43.04 of the Mental Hygiene Law shall be included in the rate. Effective April 1, 1999, costs in excess of 0.3 percent incurred as a result of the provider of services assessment charged on cash receipts pursuant to section 43.04 of the Mental Hygiene Law shall be included in the rate. Effective April 1, 2000, the assessment charged on cash receipts pursuant to section 43.04 of the Mental Hygiene Law shall be a reimbursable expense.

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- (iv) Allowable operating costs shall also include, but not be limited to, personal service, fringe benefits, OTPS, utility, administration costs, as well as day treatment, day services, and transportation costs, and regional FTE add-ons.
- (v) Liability for compensated absences determined and accrued in accordance with generally accepted accounting principles for governments as promulgated by the Governmental Accounting Standards Board shall be considered an allowable cost.

(3) Allowable costs (capital).

- (i) Start-up costs are those costs which are incurred from the period the provider receives approval pursuant to 14 NYCRR Part 620 for a facility to become an intermediate care facility to the date the first consumer is admitted. However, costs incurred during the period from the first admission to the effective date of the initial provider agreement shall not be considered as start-up costs.

- (a) OMRDD may, at the discretion of the commissioner, reimburse a provider for all allowable start-up costs incurred in the preparation of the provider during that six-month period prior to the date of the first consumer admission. A provider may apply to the commissioner for an extension of the six-month reimbursable start-up period, provided that the provider can demonstrate why such an extension is necessary. However, under no circumstances shall a facility be allowed reimbursement of start-up costs for any period of time exceeding 18 months prior to the date of the first consumer admission.

- (b) Allowable start-up costs may include, but not be limited to:

- (1) personal service expenses;
- (2) utility expenses;
- (3) taxes;
- (4) insurance expenses;
- (5) employee training expenses;
- (6) housekeeping expenses;

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- (7) repair and maintenance expenses; and
- (8) administrative expenses.
- (c) Any costs that are properly identifiable as organization costs, or capitalizable as construction costs, shall be classified as such and excluded from start-up costs.
- (d) If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility shall be accumulated in a single deferred account and shall be amortized from the date of the first consumer admission. However, if a provider intends to prepare only portions of its facility (e.g., preparation of a floor or wing), start-up costs shall be capitalized and amortized separately. In either case, unless reimbursed as described in [subparagraph (iv) of this paragraph] paragraph (3) of subdivision (j) of the ICF/DD section of this Plan, start-up costs shall be amortized over a period not to exceed 60 months from the date of the first consumer admission.
- (ii) Any cost of the sale, purchase, alteration, construction, rehabilitation and/or renovation of a physical plant or interest in real property manifested by cooperative shares shall be considered allowable up to the amount approved by the commissioner and the director of the Division of the Budget.
  - (a)(ii) For any transaction resulting in a change of ownership, the valuation of the assets shall be limited to the lesser of the allowable acquisition cost of the assets to the first owner of record who has received Medicaid payment for the assets) in question on or after August 1, 1982, minus any paid depreciation i.e., seller's net book value) or the acquisition cost of the asset to the new owner.
  - (b) Costs including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies (attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger) for which any payment has previously been made under Medicaid, shall not be allowable for reimbursement.
- (iii) A facility's annual rental payments for real property and maintenance charges associated with cooperative shares may be considered an allowable cost subject to the following conditions:

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- (a) The lease, or in the case of cooperative shares, the subscription agreement, is reviewed by and acceptable to OMRDD and any other State agency which must by law or regulation review and approve reimbursement rates.
- (b) The lease agreement must be considered an "arm's-length transaction" not involving an affiliate, controlling person, immediate family or principal stockholder. The "arm's-length transaction" requirement may be waived by the commissioner upon application for those corporations holding title to the intermediate care facility's physical plant, created pursuant to the Not-for-Profit Corporation Law with the approval of the commissioner.
- (c) For the purposes of this section, affiliate means:
  - (1) with respect to a partnership, each partner thereof;
  - (2) with respect to a corporation, each officer, director, principal stockholder and controlling person thereof;
  - (3) with respect to a natural person, each member of said person's immediate family, or each partnership and each partner of such person, or each corporation in which said person or any affiliate of said person is an officer, director, principal stockholder or controlling person.
- (d) For the purposes of this section, controlling person of any corporation, partnership or other entity means any person who by reason of a direct or indirect ownership interest whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interest, to direct or exert a controlling influence on the direction of the management policies of said corporation, partnership or other entity. Neither the commissioner, nor any employee of the OMRDD, nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a facility, shall by reason of his or her official position be deemed a controlling person of any corporation, partnership or other entity; nor shall any person who serves as an officer, administrator or other employee of any corporation, partnership or other entity, or as a member of a board of directors or trustees of any corporation, be deemed to be a controlling

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person of such corporation, partnership or other entity solely as a result of such position or his or her official actions in such position.

- (e) For the purposes of this section, immediate family means brother, sister, grandparent, grandchild, first cousin, aunt or uncle, spouse, parent or child of such person, whether such relationship arises by reason of birth, marriage or adoption.
- (f) For the purposes of this section, principal stockholder of a corporation means any person who beneficially owns, holds or has the power to vote, 10 percent or more of any class of securities issued by said corporation.
- (g) The rental amount is comparable to similar leases for properties with similar functions in the same geographic area.
- (h) If the criteria in this paragraph are not met, reimbursement for lease costs will be the lower of lease costs or the amount determined in accordance with subparagraphs (iv) and (vii) of this paragraph.
- (i) Existing leases shall be approved during the original term of the lease. However, lease options to renew shall not be exercised without review and approval of the parties listed in clause (a) of this subparagraph. Such review and decision shall occur more than 30 days before the last date the option may be exercised, the date of which the facility has notified OMRDD in accordance with clause (j) of this subparagraph.
- (j) Effective January 1, 1983, requests for approval of lease renewals must be submitted whenever possible at least 120 days prior to the last date for the exercise of the lease renewal option.
- (iv) Depreciation shall be an allowable cost when based upon factors of historical costs and useful life of buildings, fixed equipment and/or capital improvements or acquisition of an interest in real property manifested by cooperative shares. For the purpose of this section:
  - (a) Unless an exception is made by the commissioner, the useful life shall be the higher of the reported useful life or those from the Estimated Useful Lives of Depreciable Hospital Assets (1983 edition), published by the American Hospital Association, and

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available by writing to the American Hospital Association, 840 Lake Shore Drive, Chicago, IL 60611. In certain instances, a useful life that is based upon historical experience as shown by documentary evidence and approved by OMRDD may be allowed.

- (b) The depreciation method used shall be the straight-line method.
- (c) In the event that the historical cost of the facility cannot be adequately determined by the commissioner, an appraisal value shall be the basis for depreciation. The appraisal of the historical cost of assets shall produce a value approximating the cost of reproducing substantially identical assets of like type, quality, and quantity at a price level and in a bona fide market as of the date of acquisition. Such appraisal shall be conducted by an appraiser approved by OMRDD and pursuant to a method approved by OMRDD.
- (d) (iii) Notwithstanding subparagraph (f)(1)[(ix)] (viii) of this paragraph, in the case of any provider which has been notified by OMRDD on or after April 1, 1986 that there is a preliminary reservation of State aid funds for a capital grant pursuant to Mental Hygiene Law, section 41.18(c) or [section] 41.23, the basis for computing depreciation on the facility which is the subject of the capital grant shall include the facility's depreciable project costs which were funded with such capital grant, provided that the provider is not receiving and does not have a commitment to receive HUD funding for the facility, and has not repaid the entire principal owed on the real property of the facility. If the depreciable project costs are adjusted after audit, the basis for computing depreciation on the facility will be changed to such adjusted depreciable project costs. Upon full repayment of principal, the basis for depreciation for the facility will cease to include the amount of the capital grant. Any provider which receives such a capital grant shall enter into certain assurances with the OMRDD whereby the provider agrees that:

(1) (a) The difference between depreciation in the rate attributable to the facility's depreciable project costs (other than depreciation attributable to the provider's equity in the facility's real property at the time such property is put into use as a facility) and the principal

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which is repaid shall be deposited in a secure investment approved by the commissioner.

(b) Withdrawals from such investment shall be made only for the purpose of repayment of indebtedness owed on the real property of the facility. With the commissioner's approval based on cost savings, a provider may use withdrawals from such investment for repayment of indebtedness owed on the real property of another facility which received a capital grant under this subparagraph or under subparagraph (ix) of this paragraph, or if there is no such other facility which is mortgaged, for the repayment of indebtedness owned on the real property of another facility which is mortgaged under the same mortgage as the facility.

- (c) Each withdrawal must be approved by the commissioner.
- (d) If the provider ceases to operate the facility as an intermediate care facility for the developmentally disabled, or as any facility certified by OMRDD, it will repay to OMRDD the balance on deposit in the secure investment at the time of such cessation, including interest earned on the investment.
- (e) Depreciable project costs shall mean those acquisition and construction costs of a facility which have been approved, either before or after audit, by the New York State Office of the State Comptroller or by OMRDD or by OMRDD's designee. Such costs shall include the cost of land.
- (f) HUD funding shall mean lower income housing assistance under section 8 of the United State Housing Act of 1937, as amended 42 U.S.C. section 1437(f) and/or a loan or loans pursuant to section 202 of the Housing Act of 1959, as amended 12 U.S.C. section 1701(q).

(iv) Notwithstanding subparagraph (f)(1)(viii) of this paragraph, any provider which has been notified by OMRDD before April 1, 1986 that there is a preliminary reservation of State aid funds for a capital grant pursuant to Mental Hygiene Law, section 41.18 (c) or section 41.23, which is not receiving and has no commitment to receive HUD funding for the facility which is the subject of the capital grant, may apply to the commissioner to have the basis for computing depreciation on the facility include the facility's depreciable project costs which were funded with the capital grant. Such application must be submitted to the commissioner on or before September 30, 1986 on the forms prescribed by the commissioner. Such application shall be granted at the discretion of the commissioner upon a showing that inclusion in the depreciation basis of the facility's depreciable projects which were funded with the capital grant is necessary

to the financial viability of the facility and will not impede the facility's efficient and economical operation. If the commissioner approves such application, the facility's rate shall be revised retroactive to April 1, 1986 to include in the depreciation basis the facility's depreciable project costs which were funded with the capital grant, and the provider shall enter into certain assurances described in subparagraph (iii) of this paragraph. Upon full repayment of principal, the basis for depreciation for the facility will cease to include the amount of the capital grant. If the depreciable project costs are adjusted after audit, the basis for computing depreciation on the facility will be changed to such adjusted depreciation project costs.

- (v) Effective April 29, 2005, for non State operated facilities, costs incurred as a result of requests for criminal history record information under section 16.33 of the New York State Mental Hygiene Law and section 845-b of the New York State Executive Law shall be allowable costs and shall be considered part of the rate.

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**[v](vi)** Advance refunding costs incurred in connection with the refunding of bonds, and determined in accordance with generally accepted accounting principles, shall be an allowable cost

**(g)** Trend factors.

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(1) As appropriate, OMRDD shall apply trend factors to each facility's total reimbursable operating costs as determined by subdivision (c)-(f) and as submitted on the budget or cost reports required by section (a)(1)(i) and (ii) respectively. Except for educational and related services as defined at (3)(viii)(b)(3), such trend factors shall be applied to only reimbursable operating costs, with capital costs and start-up costs added to this result to compute the final rate.

(i) For all facilities, effective on the first day of the applicable fiscal cycle the trend factor utilized shall be that figure developed by the New York State Office of Mental Retardation and Developmental Disabilities.

(2) Effective January 1, 2006, for all facilities, in addition to the trend factor identified in subparagraph (1) (i), a variable adjustment within a range of zero percent to three percent [may] shall be applied to the rate. This variable adjustment shall be that figure developed by the New York State Office of Mental Retardation and Developmental Disabilities from a review of the provider's application and historical expenditures for fringe benefits as a result of an initiative aimed at improving the recruitment and retention of the facility's lower paid employees, e.g., health care .

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**[(2)](3)** Where appropriate, the commissioner shall use some combination in whole or in part of the yearly components to project cost data into the appropriate rate period.

**(h) Appeals to rates.**

**(1)** The commissioner will consider only the following appeals for adjustment to the rates which would result in an annual increase of \$1,000 or more in a facility's allowable costs, and are:

- (i)** needed because of changes in the statistical information used to calculate a facility's staffing or utilization standards; or
- (ii)** requests for relief from the standards contained in subdivisions (d) or (e) of this section which were applied to costs used in calculating the base period and subsequent period rates.
- (iii)** Appeals for adjustments needed because of material errors in the information submitted by the facility which OMRDD used to establish the rate, or material errors in the rate computation.
- (iv)** Appeals for significant increases or decreases in a facility's overall base period operating costs due to implementation of new programs, changes in staff or service, changes in the characteristics or number of individuals, changes in a lease agreement so as not to involve a related party, capital renovations, expansions or replacements which have been either mandated or approved by the commissioner and, except in life-threatening situations, approved in advance by the appropriate State agencies.

**(2) Notification of first level appeal.**

- (i)** In order to appeal a rate in accordance with subparagraphs (1)(ii-iii) of this subdivision, the facility must send to OMRDD an appeal application by certified mail, return receipt requested, either within 90 days of the facility receiving the rate computation or within 90 days of the beginning of the rate period in question, whichever is later.

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- (ii) In order to appeal a rate in accordance with subparagraphs (1)(i and iv) of this subdivision, the facility must send to OMRDD, within one year of the close of the rate period in question, a first level appeal application by certified mail, return receipt requested.
- (3) First level rate appeal applications shall be made in writing to the commissioner.
  - (i) The application shall set forth the basis for the first level appeal and the issues of fact. Appropriate documentation shall accompany the application and OMRDD may request such additional documentation as it deems necessary.
  - (ii) Actions on first level rate appeal applications will be processed without unjustifiable delay.
- (4) The burden of proof on the first level appeal shall be on the facility to demonstrate that the rate requested in the appeal is necessary to ensure efficient and economical operation.
- (5) A rate revised by OMRDD pursuant to an appeal shall not be considered final unless and until approved by the State Division of the Budget.
- (6) At no point in the first level appeal process shall the facility have a right to an interim report of any determinations made by any of the parties to the appeal. At the conclusion of the first level appeal process OMRDD shall notify the facility of any proposed revised rate or denial of same by certified mail, return receipt requested. OMRDD shall inform the facility that the facility may either accept the proposed revised rate or request a second level appeal in accordance with 14 NYCRR section 602.9 [of this Title] in the event that the proposed revised rate fails to grant some or all of the relief requested.
- (7) If OMRDD approves the revision to the rate and State Division of the Budget denies the revision, the facility shall have no further right to administrative review pursuant to this section.
- (8) Any rate revised in accordance with this subdivision shall be effective according to the dates indicated in the rate appeal notification.
- (9) Any additional reimbursement received by the facility, pursuant to a rate revised in accordance with this subdivision, shall be restricted to the specific purpose set forth in the appeal decision.
- (10) Second level appeals to rates.

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- (i) OMRDD's denial of the first level appeal of any or all of the relief requested in the appeals provided for in paragraph (1) of this subdivision shall be final, unless the facility requests a second level appeal to the commissioner in writing within 30 days of service of notification of denial or proposed revised rate.
  - (ii) Second level appeals shall be brought and determined in accordance with the applicable provisions of 14 NYCRR Part 602.
- (i) Reserve bed days for overnight absences for hospitalization or leaves of absence in facilities.
- (1) Payment.
    - (i) Payment for overnight absences due to hospitalization shall be in accordance with 18 NYCRR section 505.9.
    - (ii) Payment for overnight absences due to leaves of absence shall be in accordance with 18 NYCRR section 505.9 and the following additional requirements.
      - (a) A leave of absence due to visits with relatives or friends, must not be medically or programmatically contraindicated.
      - (b) In the case of a leave of absence due to medically acceptable therapeutic leave or rehabilitative plans of care, the plan of care must be documented.
      - (c) Leaves of absence covered under the bed reservation program must be provided for in the consumer's individual program plan as designated by the interdisciplinary team.
      - (d) Such planning should most appropriately take place during the development and monitoring process of the individual program plan during the quarterly and annual reviews. A consumer's assigned bed cannot be reserved if another person is occupying that bed.
  - (2) Reporting.
    - (i) Each facility shall maintain an absence register for each consumer who is absent overnight.

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- (ii) The facility shall record the duration and purpose of each absence and make an annotation indicating whether or not the consumer's bed was reserved.
- (iii) Each month the facility shall complete a report summarizing all consumer absences and submit the report to OMRDD. The facility shall submit the report to the consumer's sponsoring local social services district within ten working days following the end of the month. This report shall reflect the information contained in each consumer's absence register.
- (iv) The facility shall report reserve bed absences in the form and format as prescribed by the commissioner.

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(j) General Rules for Capital Costs and Costs of Related Party Transactions

(1) Determination of Whether a Transaction is Between Related Parties

- (i) Where a transaction is not presumed to be between related parties under subparagraphs (ii) or (iv) below, OMRDD will determine whether the transaction is between related parties.
  - (a) Such determination shall be made on a case-by-case basis.
  - (b) Such determination shall be based on whether the facts and circumstances of the transaction, and the parties' situation and history, indicate that the party from whom the provider or consumer obtained the real property, equipment, goods, services or property is a related party.
  - (c) If a transaction is between a provider or consumer and a party not presumed to be a related party (under subparagraphs (ii) or (iv) below), OMRDD never-the-less can determine that the transaction is between related parties (using the criteria in subparagraph (i)(b) above), where the party transacting with the provider or consumer directly or indirectly obtained the real property, equipment, goods, services or property in question from someone or an organization presumed to be related to the provider or consumer (under subparagraphs (ii) or (iv) below).
- (ii) The existence of any of the conditions in clauses (a) through (f) below will create a presumption that the transaction is between a provider and a related party.
  - (a) The provider is a partnership and the other party to the transaction is a partner of the provider.

(b) The provider is a corporation and the other party to the transaction is an officer, director, trustee, principal stockholder or controlling party of the provider.

(c) The provider is a corporation and the other party to the transaction is a corporation, where someone is an officer, director, trustee, principal stockholder or controlling party of both corporations.

(d) The provider is a natural person and the other party to the transaction is either:

(1) a member of the provider's immediate family ;

(2) a partnership in which the provider is a partner;

(3) a co-partner of the provider;

(4) a corporation in which the provider is an officer, director, trustee, principal stockholder or controlling party;

(5) a corporation in which a member of the provider's immediate family is an officer, director, trustee, principal stockholder or controlling party;

(6) a corporation in which any partnership in which the provider is a partner is a principal stockholder;

(7) a corporation in which a co-partner of the provider is an officer, director, trustee, principal stockholder or controlling party, or

(8) a corporation in which another corporation is a principal stockholder, where the provider is an officer, director, trustee, principal stockholder or a controlling party of such other corporation.

(e) The provider is an unincorporated association and the other party to the transaction is either:

(1) someone who is a member of the provider;

(2) someone, a member of whose immediate family is a member of the provider;

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- (3) a partnership in which one partner is a member of the provider;
- (4) a corporation in which a member of the provider is an officer, director, trustee, principal stockholder or controlling party;
- (5) a corporation in which a member of the provider has an immediate family member who is an officer, director, trustee, principal stockholder or controlling party;
- (6) a corporation in which any partnership, in which a member of the provider is a partner, is a principal stockholder;
- (7) a corporation in which a co-partner of a member of the provider is an officer, director, trustee, principal stockholder or controlling party, or
- (8) a corporation in which another corporation is a principal stockholder, where a member of the provider is an officer, director, trustee, principal stockholder or a controlling party of such other corporation.

(f) The other party to the transaction is a special purpose organization .

(iii) A provider may overcome a presumption that the transaction is between related parties by clearly demonstrating that:

- (a) The other party to the transaction in question is a bona fide separate organization;
- (b) A substantial part of the other party's business activity of the type carried on with the provider is transacted with other organizations or those not related to the provider and the other party by common ownership or control and there is an open, competitive market for the type of real property, equipment, goods, services or property furnished by the other party;
- (c) The real property, equipment, goods, services or properties are those which commonly are obtained by organizations such as the provider from other organizations and are not a basic element of care ordinarily furnished directly to consumers by such programs, and

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- (d) The charge to the provider is comparable to the charge for such real property, equipment, goods, services or property in the open market and no more than the charge made under comparable circumstances to others by the other party to the transaction for such real property, equipment, goods, services or property.
- (iv) The existence of any of the conditions in clauses (a) through (e) below will create a presumption that the transaction is between a consumer and a related party.
  - (a) The other party to the transaction is a member of the consumer's immediate family.
  - (b) The other party to the transaction is a partnership in which the consumer or a member of the consumer's immediate family is a partner.
  - (c) The other party to the transaction is a corporation in which the consumer or a member of the consumer's immediate family is an officer, director, trustee, principal stockholder or controlling party.
  - (d) The other party to the transaction is a corporation in which:
    - (1) any partnership, in which the consumer or a member of the consumer's immediate family is a partner, is a principal stockholder, or
    - (2) another corporation is a principal stockholder, where the consumer or a member of the consumer's immediate family is an officer, director, trustee, principal stockholder or controlling party of such other corporation.
  - (e) The other party to the transaction is an unincorporated association which has as a member either:
    - (1) the consumer;
    - (2) a member of the consumer's immediate family;
    - (3) a partnership in which the consumer or a member of the consumer's immediate family is a partner;
    - (4) a corporation in which the consumer or a member of the consumer's immediate family is an officer, director, trustee,

principal stockholder or controlling party;

- (5) a corporation in which any partnership, in which the consumer or a member of the consumer's immediate family is a partner, is a principal stockholder, or
- (6) a corporation in which another corporation is a principal stockholder, where the consumer or a member of the consumer's immediate family is an officer, director, trustee, principal stockholder or a controlling party of such other corporation.

(2) Leases for Real Property

- (i) In order for lease costs to be considered for allowability, the provider or consumer must submit the lease to OMRDD for approval. In deciding whether to approve a lease, OMRDD shall consider whether the lease is in the best interests of the programs and the persons it serves and whether the lease in any way violates public policy. In deciding whether to approve an amount for rent, OMRDD shall consider whether the provider's rate, fee or price, as a whole, including the amount of rent to be approved, would result in payment which is consistent with efficiency and economy.
- (ii) If an approved lease or approved proprietary lease is between the provider or consumer and a party which is not a related party, allowable lease costs shall be the lesser of contract rent or fair market rental.
- (iii) If an approved lease or approved proprietary lease is between the provider or consumer and a related party, allowable lease costs shall be the least of:
  - (a) contract rent,
  - (b) fair market rental, or
  - (c) the landlord's net cost (see subdivision (k), glossary)
- (iv) The Commissioner may waive the limitations on allowable costs as stated in subparagraph (iii) above upon a showing that such limitations would jeopardize the opening or continued operation of the program or services and that the negotiations for the lease or proprietary lease were conducted as though the parties were not related.
- (v) The commissioner may, upon application from a provider, allow lease costs in an

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amount equal to contract rent and greater than fair market rent if the following conditions are met. The commissioner will allow such lease costs only for as long as it is necessary for the provider to relocate the program or services located on the lease property.

- (a) the lease is a renewal which is not pursuant to an option to renew;
- (b) the lease is a renewal of a lease for an existing program or services, and
- (c) the provider has shown that:
  - (1) the provider has made diligent efforts to negotiate a lease renewal for fair market rent or less;
  - (2) the provider has been unable to negotiate a lease renewal for less than the current rent;
  - (3) the parties to the lease renewal are not related;
  - (4) allowance of lease costs in the amount of contract rent is necessary to ensure the continued operation of the program of services.

(vi) From October 1, 2000 until January 1, 2001, allowable costs under leases between related parties in effect on September 1, 1984 shall be determined in accordance with the State Plan in effect on September 30, 2000. On and after January 1, 2001, allowable costs under leases between related parties in effect on September 1, 1984 shall be determined in accordance with subparagraph (iii) above.

(vii) Contract rent incurred pursuant to an approved lease or approved proprietary lease which is renewed pursuant to an option to renew is allowable.

(viii) Costs incurred pursuant to an approved lease or approved proprietary lease which is renewed other than pursuant to an option to renew shall be allowable as follows:

- (a) If the lease is between parties who are not related, allowable costs are determined in accordance with subparagraph (ii) above.
- (b) If the lease is between parties who are related, allowable costs are determined in accordance with subparagraph (iii) above.

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- (c) OMRDD shall decide whether to approve any such renewal at least 30 days before the last day the lease may be renewed, if the provider or consumer has notified OMRDD in accordance with subclause (d) below.
- (d) Whenever possible, the provider or consumer shall submit to OMRDD a request for approval of lease renewals at least 120 days prior to the last date for renewing the lease.

(3) Costs of Ownership of Real Property

- (i) Unless specifically otherwise provided for in this part of the Plan, costs of ownership of real property shall be allowable in the amount of depreciation, interest and costs attributable to the negotiation or settlement of sale or purchase of real property, or in the amount of costs related to loans from the Dormitory Authority of the State of New York.
- (ii) Depreciation is based upon the historical cost and useful life of buildings, fixed equipment and/or capital improvements.
- (iii) Historical cost shall be determined as follows:
  - (a) The historical cost of any real property which is transferred, purchased, altered, constructed, rehabilitated and/or renovated shall be equal to the amount approved by the OMRDD and the Division of the Budget. In deciding whether to approve any such cost, OMRDD shall consider whether the provider's reimbursement as a whole for the services in question, including the cost of purchase, transfer, construction, alteration, rehabilitation and/or renovation to be approved, would result in payment which is consistent with efficiency and economy. In no event shall OMRDD or the Division of Budget approve an historical cost which exceeds the lesser of fair market value or the provider's or consumer's actual cost.
  - (b) The historical cost of any real property which is transferred or purchased from a party related to the provider or consumer is the lesser of fair market value or the acquisition cost of the real property to the transferor or the seller.
  - (c) The historical cost of any real property which is altered, constructed, rehabilitated and/or renovated by a party related to the provider or consumer is the lesser of:
    - (1) the fair market value of such alteration, construction, rehabilitation or renovation, or
    - (2) the related party's cost of the alteration, construction, rehabilitation

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or renovation.

(iv) Where the previous owner of the real property had the costs of such property funded, in whole or in part, by the State of New York, the historical cost of the property shall be the least of:

- (a) the acquisition cost of the property to the new owner;
- (b) the seller's net book value (see subdivision (k), glossary), or
- (c) fair market value.

(v) If the previous owner is related to the provider or consumer purchasing the property, any amount paid by the State to the provider or consumer for rent equal to depreciation on the property shall be counted as paid depreciation and as funding for the costs of such property.

(vi) If the seller or transferor of the real property to the provider or consumer is not a party related to the provider or consumer, but any prior owner of the property in question is a party related to the provider or consumer, and the sale or transfer from the prior related party occurs within five years of the sale or transfer to the provider or consumer, the transaction shall be deemed to be between the provider or consumer and the prior owner related to the provider or consumer.

(vii) If OMRDD cannot determine the historical cost of real property, OMRDD shall use an appraisal value as the basis for depreciation. The appraisal value shall be based upon an appraisal which is done by OMRDD or by an appraiser approved by OMRDD, which uses an appraisal methodology which is generally accepted within the profession and which is factually correct in all significant matters. OMRDD shall approve an appraiser if one of the following tests is met:

- (a) the appraiser is a New York State certified or licensed appraiser, or
- (b) no licensed or certified appraiser is available in the geographic area in which the property is located; the appraiser is recommended by another State agency and, in OMRDD's opinion, the appraiser has the professional experience and qualifications to do the appraisal in question.

(viii) The commissioner may allow an alternative historical cost of ownership of real property obtained from a related party.

- (a) The commissioner may allow such alternative historical cost if

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(1) the provider or consumer demonstrates that allowing such alternative historical cost would make property available to consumers or providers which would not otherwise be available;

(2) such alternative historical cost is substantially less than the cost which would be allowed under this subpart for property which is obtained from an unrelated party and which is of similar function and value to OMRDD and to the provider or consumer;

(3) the seller or transferor has owned the property in question for at least five years, and

(4) the fair market value of such property is greater than the seller's cost.

(b) Such alternative historical cost may be greater than the cost of the property to the transferor or seller, but shall not be greater than the lesser of:

(1) the acquisition cost of the property to the provider or consumer, or

(2) the cost of the property to the seller or transferor, increased by one-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for New York - Northeastern New Jersey (All items), as reported by the United States Department of Labor, Bureau of Labor Statistics.

(c) The commissioner may allow an alternative historical cost only for transfers, purchases, alteration, construction, renovation or rehabilitation, the terms of which were agreed to after October 1, 2000.

(ix) Useful Life and Amortization Period.

(a) The useful life of depreciable assets shall be the higher of the reported useful life or the useful life from the Estimated Useful Lives of Depreciable Hospital Assets (current edition).

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published by the American Hospital Association.

(b) A provider or consumer may use a different useful life or amortization period if such different useful life is approved by OMRDD. OMRDD shall base such approval upon historical experience, documentary evidence, loan agreements (if any) and need for the services for which depreciable assets are used.

(x) The provider or consumer shall use the straight-line method of depreciation.

(xi) Interest costs.

(a) Interest costs shall be allowable if the following criteria are met:

(1) The interest rate is not in excess of the amount a prudent borrower would pay at the time the loan was incurred.

(2) The loan agreement is entered into between the provider or consumer and a party not related to the provider or consumer. The commissioner may waive this provision based on a demonstration of need for the services and cost savings resulting from the transaction.

(3) If the interest expense results from either start-up costs and/or the initial financing of the capital indebtedness, the capital indebtedness shall represent all or part of the current OMRDD and Division of the Budget approved value of the property, after subtracting any equity contributions such as, but not limited to, grants applied to the property.

(4) In the case of interest expense, or a portion of interest expense, resulting from the refinancing of the capital indebtedness, the refinancing has the prior approval of the commissioner and the Division of the Budget, and the interest is in the amount associated with the outstanding principal balance prior to refinancing.

(b) Interest expense resulting from the inclusion of the reasonable closing costs, such as, but not limited to, attorney's fees, recording costs and points, is allowable in the initial financing and start-up costs, and in the refinancing of the capital indebtedness.

(c) Interest income generated from the provider's revenues for the operation of the services shall be used to offset interest expense incurred during the same reporting period. Notwithstanding the foregoing, a provider is not required to use the following to offset

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interest expense: income earned on qualified pension funds, income from gifts or grants which are donor-restricted, income earned on funded depreciation accounts or secure investments for depreciable project costs above principal repayments.

(xii) Where any real property for which previous Medicaid payment has been made is transferred by sale, purchase, acquisition or merger (other than as a result of a receivership under New York Mental Hygiene Law, section 16.27), the costs (including legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies) attributable to the negotiation or settlement of sale or purchase are not allowable.

(xiii) Costs related to Dormitory Authority loans shall be allowable as follows:

(a) The cost of principal and interest payments on loans from the Dormitory Authority pursuant to subdivision 13-d of section 5 of the Facilities Development Corporation Act, net of the portion of such payments attributable to operating costs, are allowable; provided that the reimbursement of such costs is an allowance in lieu of reimbursement of interest and depreciation associated with the property, and in lieu of reimbursement of the underlying allowable costs, which may include allowable start-up costs, for which the Dormitory Authority loan is received. A provider which receives a Dormitory Authority loan shall not have the option of having included, in the calculation of its rate, fee or price, the loan's underlying costs instead of the loan principal and interest payments.

(b) Operational period fees imposed by OMRDD and annual administrative fees imposed by the Dormitory Authority in connection with Dormitory Authority mortgage loans shall be allowable costs.

(c) Interest payments on Dormitory Authority loans pursuant to this subparagraph (xiii) for capital indebtedness and start-up costs will be considered allowable where interest expense results from capital indebtedness and start-up costs in an amount equal to the OMRDD and Division of Budget approved value of the loan.

(d) Interest payments on Dormitory Authority loans pursuant to the provisions of subparagraph (xiii) are allowable in excess of the amount associated with the outstanding principal balance prior to refinancing, if the purpose of the debt is to acquire assets to be used for care of the persons served by the program or services and all other applicable requirements of this Plan are met.

(4) Costs of Co-operative (see subdivision (k), glossary) Ownership of Real Estate

(i) If an agreement to purchase membership or ownership interest in a co-operative, which agreement has been approved by OMRDD and the New York State Division of Budget, is

agreement has been approved by OMRDD and the New York State Division of Budget, is between the provider or a consumer and a party which is not a related party, allowable costs shall be the lesser of the actual purchase price or the price of a membership or ownership interest in a co-operative for real estate with similar functions in the same geographic area.

(ii) If an agreement to purchase membership or ownership interest in a co-operative, which agreement has been approved by OMRDD and the New York State Division of Budget, is between the provider or a consumer and a related party, allowable costs for such purchase shall be the least of:

- (a) the actual purchase price.
- (b) the price of membership or ownership interest in a co-operative with similar functions in the same geographic area, or
- (c) the co-operative's costs attributable to the provider or consumer.

(iii) The allowable cost of purchasing membership or ownership interest in a co-operative shall be amortized over fifteen years, or the term of the mortgage given by the provider or consumer, whichever is greater.

(5) Moveable Equipment and Personal Property

(i) Costs of ownership of moveable equipment and personal property shall be allowable in the amount of depreciation and interest if the purchase is made through a multiple bid process. Depreciation shall be based upon the historical cost and useful life.

(a) If the equipment or personal property is purchased from a party not related to the provider or consumer, the historical cost shall be the lesser of the actual cost of purchasing the equipment or personal property or the fair market value of such equipment or personal property.

(b) If the equipment or personal property is purchased from a party related to the provider or the consumer, the historical cost shall be the least of:

- (1) actual acquisition cost.
- (2) fair market value, or
- (3) the seller's cost.

(c) The useful life is the higher of the reported useful life or the useful life as reported in the Estimated Useful Lives of Depreciable Hospital Assets (current edition), published by the American Hospital Association. A provider or consumer may

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OMRDD shall base such approval upon historical experience and documentary evidence.

(d) The provider or consumer shall use the straight-line, double declining balance or sum-of-the-years' digits depreciation method. Once selected, the depreciation method shall remain constant for the useful life of the asset.

(ii) Costs of leasing moveable equipment and personal property shall be allowable as follows:

(a) If lease payments are made to a party which is not a related party, allowable costs shall be the lesser of:

(1) actual lease payments, or

(2) fair market rental.

(b) If lease payments are made to a related party, allowable costs shall be the least of:

(1) actual lease payments,

(2) fair market rental, or

(3) allowable depreciation, the associated interest expense, if any, and other related expenses, including, but not limited to, maintenance costs.

(6) Costs Applicable to Goods, Services or Property Not Covered Elsewhere in this Section.

(i) Costs applicable to goods, services or property not covered elsewhere in the ICF/DD portion of this Plan and furnished to the provider or consumer by a related party shall be allowable at the lesser of:

(a) the cost to the related party, or

(b) the price of comparable goods, services or properties that could be obtained elsewhere.

(ii) Interest on working capital indebtedness in accordance with subparagraph (xi) of paragraph (3) of the ICF/DD portion of this Plan are allowable. In the event that a loan is not in accordance with the standards listed in subparagraph (xi), the need for such loan shall be demonstrated in writing to the commissioner, and the express written approval of the commissioner is required.

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(k) Glossary

(1) Approved lease - A lease approved by OMRDD and the New York State Division of the Budget.

(2) Approved proprietary lease - A proprietary lease approved by OMRDD and the New York State Division of Budget

(3) Common ownership - An individual or individuals possessing significant ownership or equity in the provider and the organization serving the provider.

(4) Consumer - Anyone with a diagnosis of developmental disability who receives services from OMRDD or from a provider, or anyone to whom OMRDD provides funds (other than payment for competitive employment with OMRDD) to purchase services from a provider or to purchase other goods, services or property.

(5) Control - The power, directly or indirectly, to significantly influence or direct the actions or policies of someone or an organization.

(6) Controlling party - An organization or someone who, by reason of a direct or indirect ownership interest (whether of record or beneficial), has the ability, acting either alone or in concert with others with ownership interest, to direct or exert a controlling influence on the management policies of the provider. Except as otherwise provided in this section, neither the commissioner, nor any employee of the OMRDD, nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a program, shall by reason of his or her official position be deemed a controlling party of the provider; nor shall anyone who serves as an administrator or other employee of a provider be deemed to be a controlling party of such provider solely as a result of such position or his or her official actions in such position.

(7) Contract rent - The amount of rent stated in the lease or proprietary lease as rent, additional rent, maintenance, special assessments, or any other additional charges, costs, expenses, liabilities and obligations. Notwithstanding the foregoing, A contract rent shall not include an amount greater than the amount approved by OMRDD and the Division of Budget.

(8) Co-operative - A corporation or organization formed for the purpose of co-operative ownership of real estate.

(9) Co-partner - A partner in a partnership of which the provider is also a partner.

(10) Dormitory Authority - The Dormitory Authority of the State of New York as successor to the Facilities Development Corporation, and the Dormitory Authority of the State of New York as the successor to the Medical Care Facilities Finance Agency.

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(11) Fair market rental - The rental that the property would most probably command on the open market as indicated by rentals being paid and asked for comparable properties in the same geographic area as of the date of the appraisal.

(12) Fair market value -

(i) In the case of goods and services, the price of comparable goods and services that could be obtained elsewhere.

(ii) In the case of real property, the most probable price which a property should bring in a competitive and open market under all conditions requisite to a fair sale, the buyer and seller each acting prudently and knowledgeably, and assuming the price is not affected by undue stimulus. Implicit in this definition is the consummation of a sale as of a specified date and the passing of title from seller to buyer under conditions whereby:

(a) buyer and seller are typically motivated;

(b) both parties are well-informed or well-advised, and acting in what they consider their own best interest;

(c) a reasonable time is allowed for exposure in the open market;

(d) payment is made in terms of cash in U.S. dollars or in terms of financial arrangements comparable thereto, and

(e) the price represents the normal consideration for the property sold unaffected by special or creative financing or sales concessions granted by anyone associated with the sale.

(13) Immediate family - Brother, sister, grandparent, grandchild, first cousin, aunt, uncle, spouse, parent or child of an individual, whether such relationship arises by reason of birth, marriage or adoption.

(14) Landlord's net cost - The amount equal to depreciation (subject to the limitations in section (j), the associated interest expense on capital indebtedness, if any, and other expenses approved by OMRDD. OMRDD shall approve such other expenses if they are reasonable in an amount and directly related to owning and maintaining the property in question. The types of other expenses directly related to owning and maintaining the property in question include, but are not limited to, real estate taxes, water and sewer charges, heat and utilities, maintenance costs, legal and accounting fees, lawn care, snow removal, rubbish and insurance.

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removal, rubbish and insurance.

(15) Option to renew a lease - An option, stated in a lease, to renew the lease at a specific amount of rent and term of renewal, where such rent and term of renewal were stated in the original lease at the time the parties entered into the original lease, and were not negotiated by the parties subsequent to the signing of the original lease.

(16) Organization - A corporation, partnership or unincorporated association.

(17) Principal stockholder - Someone or an organization beneficially owning, holding or having the power to vote, 10 percent or more of any class of securities issued by a corporation.

(18) Proprietary lease - A lease between a co-operative, as lessor, and a person or organization with membership or ownership interest in the co-operative, as lessee.

(19) Provider - Someone or an organization licensed or otherwise approved by OMRDD to provide goods, services or property to consumers.

(20) Related Party - Someone or an organization which to a significant extent is associated or affiliated with the consumer or provider by common ownership or control, or which to a significant extent has control of, or is controlled by, the consumer or provider, by common ownership or control.

(21) Seller's net book value - The allowable acquisition cost of the asset(s) to the first owner of record who has received payment from the State of New York for the asset(s), minus any paid depreciation.

(22) Special purpose organization - For the purpose of this subpart is:

(a) an organization which the provider controls through contracts or other legal documents that give the provider the authority to direct the organization's activities, management and policies;

(b) an organization, the activities of which the provider is, for all practical purposes, the sole beneficiary. The provider will be considered the organization's sole beneficiary if one or more of the three following circumstances exist:

(1) the provider has assigned certain of its functions to the organization and the organization is operating primarily for the benefit of the provider;

(2) the provider has transferred some of its resources to the organization.

and substantially all of the organization's resources are held for the benefit of the provider; or

(3) the organization has solicited funds in the name of and with the express or implied approval of the provider, and substantially all the funds solicited by the organization were intended by the contributor or were otherwise required to be transferred to the provider or used at its discretion or direction; or

(c) an organization which was created for the sole purpose of benefiting the provider, where the provider or such organization has been in operation for less than one year. The organization will be considered to be created for the sole purpose of benefiting the provider if the organization's or provider's certificate of incorporation, by-laws, partnership agreement or other governing rule state one or more of the following:

(1) the provider must assign certain of its functions to the organization and the organization must operate primarily for the benefit of the provider;

(2) the provider must transfer some of its resources to the organization, and substantially all of the organization's resources must be held for the benefit of the provider; or

(3) the organization shall solicit funds in the name of and with the express or implied approval of the provider, where substantially all the funds to be solicited by the organization will be intended by the contributor or otherwise required to be transferred to the provider or used at its discretion or direction.

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① Adjustments. Effective January 1, 2005 for Region II and III voluntary operated facilities, effective April 1, 2005 for all state operated facilities, and effective July 1, 2005 for voluntary operated Region I facilities, there shall be an efficiency adjustment for under-31 bed facilities as described herein and applied as a reduction to reimbursable operating costs.

(1) A determination shall be made as to whether each provider has a per bed surplus or loss for all its under-31 bed facilities.

(i) Surplus/loss shall equal operating revenue minus operating costs.

(a) For purposes of this efficiency adjustment, operating revenue and costs are net of day treatment, day service, transportation and regional FTE add-ons.

(b) Revenue for determining the surplus/ loss calculations for all facilities in all regions is from the rate effective July 1, 2004.

(c) Costs for determining the surplus/ loss calculations are from the 2001 or 2001-2002 cost reporting year, trended to 2004 or 2004-2005 dollars.

(ii) The value of the surplus/loss is divided by the total number of beds in all of the provider's under-31 bed facilities to determine the provider's per bed surplus/ loss value.

(2) Regional ranking of the per bed surplus/ loss.

(i) Within each of the three regions, the per bed surplus/loss values are ranked and identified in descending order.

(ii) Within each region, the ranking is divided into five groups:

<u>Region I</u>	<u>Surplus/ Loss Range (Per Bed)</u>
<u>Efficiency Group 5</u>	<u>\$17,498 to \$4,289</u>
<u>Efficiency Group 4</u>	<u>\$4,288 to \$523</u>
<u>Efficiency Group 3</u>	<u>\$522 to (\$2,986)</u>
<u>Efficiency Group 2</u>	<u>(\$2,987) to (\$7,465)</u>
<u>Efficiency Group 1</u>	<u>(\$7,466) to (\$42,035)</u>

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<u>Region II</u>	<u>Surplus/Loss Range (Per Bed)</u>
<u>Efficiency Group 5</u>	<u>\$17,478 to \$6,354</u>
<u>Efficiency Group 4</u>	<u>\$6,353 to \$4,081</u>
<u>Efficiency Group 3</u>	<u>\$4,080 to \$873</u>
<u>Efficiency Group 2</u>	<u>\$872 to (\$5,343)</u>
<u>Efficiency Group 1</u>	<u>(\$5,344) to (\$16,087)</u>

<u>Region III</u>	<u>Surplus/Loss Range (Per Bed)</u>
<u>Efficiency Group 5</u>	<u>\$12,398 to \$7,216</u>
<u>Efficiency Group 4</u>	<u>\$7,215 to \$2,207</u>
<u>Efficiency Group 3</u>	<u>\$2,206 to (\$1,049)</u>
<u>Efficiency Group 2</u>	<u>(\$1,050) to (\$6,440)</u>
<u>Efficiency Group 1</u>	<u>(\$6,441) to (\$15,631)</u>

(3) Each of the five groups within each region is assigned an ordinal weight.

Group 5 = 5  
Group 4 = 4  
Group 3 = 3  
Group 2 = 2  
Group 1 = 1

(4) Determination of total adjustment per facility.

- (i) The number of beds in the facility is multiplied by its assigned ordinal weight and the result is multiplied by \$334.
- (ii) The facility's reimbursable operating costs are reduced by the amount determined in subparagraph (i) of this paragraph.

(5) Reallocation of costs. The following changes to cost allocations for all under-31 bed facilities are effective January 1, 2005 for voluntary operated Region II and III facilities, effective April 1, 2005 for all state operated facilities, and effective July 1, 2005 for voluntary operated Region I facilities.

- (i) General insurance costs are reallocated from base year administration OTPS costs to base year support OTPS costs.
- (ii) Property and casualty insurance costs are removed from base year administration OTPS costs. Property and casualty insurance costs from the appropriate cost report period are included in capital costs.
- (iii) Expensed equipment costs from the base year cost report are included in Support OTPS costs. Expensed equipment costs are not included in capital costs.

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Methods and Standards for Establishing Payment Rates

Out of State Services

[Skilled Nursing and Intermediate Care Facilities (SNF's and ICF's)]

Nursing Facilities

New York State reimburses [SNF/ICF] nursing facility services provided in accordance with rates negotiated by the [recipient's district of fiscal responsibility or directly] State and the facility. The rate negotiated is based on the approved Medicaid rate established by the facility's home state. Where ancillary services for the necessary care of the recipient are not included in the home state's Medicaid rate, the rate approved by New York State may be augmented to include the additional services. All out-of-state rates, except those equal to or less than the facility's home state Medicaid rate must be approved by both the State Department of Social Services and the Division of the Budget. In those instances where the proposed rate is not approved, an alternative rate is negotiated and re-submitted to the Division of the Budget. Only one rate for a level or type of care will be established for a given out-of-state facility and will be applicable to all local districts. The implementation of a single locator code for all out-of-state billings precludes the potential for different rates being paid to the same facility on behalf of different local districts.

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SUBPART 86-2

RESIDENTIAL HEALTH CARE FACILITIES

(Statutory authority: Public Health Law, §§2803[2],2808)

- Sec.
- 86-2.1 Definition
  - 86-2.2 Financial and statistical data required
  - 86-2.3 Uniform system of accounting and reporting
  - 86-2.4 Generally accepted accounting principles
  - 86-2.5 Accountant's certification
  - 86-2.6 Certification by operator or officer
  - 86-2.7 Audits
  - 86-2.8 Patient days
  - 86-2.9 Residential health care facility services for nonoccupants
  - 86-2.10 Computation of basic rate
  - 86-2.11 Adjustments to direct component of the rate
  - 86-2.12 Adjustments to basic rate
  - 86-2.13 Adjustments to provisional rates based on errors
  - 86-2.14 Revisions in certified rates
  - 86-2.15 Rates for residential health care facilities without adequate cost experience
  - 86-2.16 Less expensive alternatives
  - 86-2.17 Allowable costs
  - 86-2.18 Recoveries of expense
  - 86-2.19 Depreciation for voluntary and public residential health care facilities
  - 86-2.20 Interest for all residential health care facilities
  - 86-2.21 Capital cost reimbursement for proprietary residential health care facilities
  - 86-2.22 Movable equipment
  - 86-2.23 Research
  - 86-2.24 Educational activities
  - 86-2.25 Compensation of operators or relatives of operators
  - 86-2.26 Costs of related organizations
  - 86-2.27 Termination of service
  - 86-2.28 Return on investment
  - 86-2.29 Payments to receivers
  - 86-2.30 Patient assessment for certified rates

86-4

*supervisor*

82-30

*Appraisal Date* JUL 29 1987

*Efficient Date*

JAN. 1 1988

New York  
1(a)

OBRA (90-10; 7/90)  
Attachment 4.19-D  
Part I

New York State provides public access to governmental records, including data and the methodology used in establishing payment rates for nursing facilities under Medicaid. The State Freedom of Information Law (Public Officers Law, Article 6) is the principal statute providing public access to information and records. Regulations related to the process of obtaining access to the Department of Health's records are contained in Sub-part 50-1 of Title 10NYCRR. These records include, but are not limited to, facility cost reports, case mix indices and the methodologies by which reimbursement rates are set for hospitals, nursing homes, and other health care providers.

Anyone wishing to inspect or obtain public records must apply to the Department's Records Access Officer in writing. The Officer is responsible for insuring appropriate agency response to requests for public access to records, and will coordinate the Department's response as per the process contained in the New York State Department of Health Administrative Policy and Procedure Manual, 100.0

- RELEASE OF INFO TO OUTSIDE GROUP/FREEDOM OF INFO/RECORD ACCESS.

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Section 86-2.1 Definitions. As used in this Subpart, the following definitions shall apply:

[(1)](a) Residential health care facility, medical facility or facility shall mean all facilities or organizations covered by the term nursing home [or health-related facility] as defined in article 28 of the Public Health Law, including hospital-based residential health care facilities, and NURSING FACILITIES as defined in Section 1919 of the federal Social Security Act, provided that such facility possesses a valid operating certificate issued by the State Commissioner of Health and, where required, has been established by the Public Health Council.

[(2)](b) Patient classification groups shall mean patient categories contained in the classification system, Resources Utilization Groups-II (RUG-II), which identifies the relative resource consumption required by different types of long term care patients as specified in Appendix [6] 13-A, infra.

[(3)](c) Case mix shall mean the patient population of a facility as classified and aggregated into patient classification groups.

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Part I

86-2.2 Financial and statistical data required. (a) Each residential health care facility shall complete and file, with the New York State Department of Health and/or its agent, annual financial and statistical report forms supplied by the department and/or its agent. Residential health care facilities certified for title XVIII of the Federal Social Security Act (Medicare) shall use the same fiscal year for title XIX of the Federal Social Security Act (Medicaid) as is used for title XVIII. All residential health care facilities must report their operations from January 1, 1977, forward on a calendar-year basis.

(1) Hospital based residential health care facilities whose affiliation changes to freestanding pursuant to subdivision.(a) of section 86-2.34 of this Subpart shall complete and file the freestanding annual cost report (RHCF-4) supplied by the department and/or its agent for the first full calendar-year following actual complete closure of the acute care beds of its affiliated hospital.

(b) Federal regulations require the submission of cost reports to the State agency no later than three months after the close of the cost reporting year. State agencies requiring certified reports may grant an extension of 30 days. Since the reports from all residential health care facilities are required to be certified, an extension of 30 days is automatically provided in this subdivision so that all required financial and statistical reports shall be submitted to the department no later than 120 days following the close of the fiscal period. Further extensions of time for filing reports may be granted upon application received prior to the due date of the report and only in those circumstances where the residential health care facility established, by documentary evidence, that the report cannot be filed by the due date for reasons beyond the control of the facility.

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(c) In the event a residential health care facility fails to file the required financial and statistical reports on or before the due dates, or as

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the same may be extended pursuant to subdivision (b) of this section, the State Commissioner of Health shall reduce the current rate by two percent for a period beginning on the first day of the calendar month following the original due date of the required reports and continuing until the last day of the calendar month in which said required reports are filed.

(d) In the event that any information or data which a residential health care facility has submitted to the State Department of Health, on required reports, budgets or appeals for rate revisions intended for use in establishing rates, is inaccurate or incorrect, whether by reason of subsequent events or otherwise, such facility shall forthwith submit to the department a correction of such information or data which meets the same certification requirements as the document being corrected.

(e) Except as identified in sections 86-2.10(k)(6) and 86-2.15(e), a cost report shall be filed in accordance with this section by each new facility for the first [six-month] twelve-month period during which the facility has had an overall average utilization of at least 90 percent of bed capacity. This report shall be filed and properly certified within 60 days following the end of the [six-month] twelve-month period covered by the report. Failure to comply with this subdivision shall result in application of subdivision (c) of this section.

(f) If the financial and statistical reports required by this Subpart are determined by the department to be incomplete, inaccurate or incorrect, the residential health care facility will have 30 days from the date of receipt of notification to provide the corrected or additional data. Failure to file the

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corrected or additional data that was previously required within that period will result in a reduction of the current rate in accordance with subdivision (c) of this section. Lack of the respective certifications by both the operator and accountant, as required pursuant to section 86-2.5 and 86-2.6 of this Subpart, shall render a financial and statistical report incomplete, and the facility shall not be entitled to the 30-day period to submit the certifications.

(g) Specific additional data related to the rate setting process may be requested by the State Commissioner of Health. These data, which include and are limited to those for use in a wage geographic differential survey, a peer grouping data survey, a medical supplies survey and a malpractice insurance survey, must be provided by the residential health care facility within 30 days from the date of receipt of notification to supply such information. The commissioner must supply to each facility prior to the start of each rate period, a preliminary listing of the data that will be required. Failure to submit the additional data shall result in a reduction of the current rate in accordance with subdivision (c) of this section, unless the residential health care facility can prove by documentary evidence that the data being requested is not available.

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[(h) each residential health care facility shall file with the New York State Department of Health a complete copy of the Department of the Treasury, Internal Revenue Service Form 990, for that facility. The Form 990 shall be submitted to the department no later than 30 days following the annual filing with the Internal Revenue Service. Failure to submit the Form 990 shall result in application of the provisions set forth in subdivision (c) of this section.]

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86-2.3 Uniform system of accounting and reporting. (a) Residential health care facilities shall maintain their records in accordance with:

(1) section 414.13 of Article 3 Subchapter A of Chapter V of this Title; and

(2) for the 1980 calendar year in substantial compliance, and thereafter in full compliance, with Article 9 of Subchapter A of Chapter V of this Title. *Substantial compliance* shall be defined as the result that would be expected from a good-faith effort taken by an informed, responsible person.

(b) For purposes of rate setting, the report required for the fiscal year beginning on or after January 1, 1980 by residential health care facilities shall be made in accordance with the policies and instructions as set forth in Article 9 of Subchapter A of Chapter V of this Title for financial presentation purposes.

(c) Rate schedules shall not be certified by the Commissioner of Health unless residential health care facilities are in full compliance with the reporting requirements of this Subpart, section 414.13 and Article 9 of Subchapter A of Chapter V of this Title. For the purpose of certifying rates, compliance with reporting requirements of Article 9 of Subchapter A of Chapter V of this Title will include, but not be limited to, the timely filing of properly certified reports which are complete and accurate in all material respects.

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(d) Failure of residential health care facility to file the reports required pursuant to this section will subject to residential health care facility to a rate reduction as set forth in section 86-2.2 of this Subpart. However, there may be instances where a facility is not in compliance with Article 9 of Subchapter A of Chapter V of this Title, resulting in reports which are inaccurate, incomplete or incorrect, and the area of noncompliance cannot, for the reporting period, be corrected. In such instances a rate reduction shall, with respect to the report for such reporting period, begin on the first day of the calendar month following the original due date of the required report and continue until the last day of the calendar year in which the report was required to be filed.

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86-2.4 Generally accepted accounting principles. The completion of the financial and statistical report form shall be in accordance with generally accepted accounting principles as applied to the residential health care facility unless the reporting instructions authorized specific variation in such principles.

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86-2.5 Accountant's certification. (a) The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant. The minimum standard for the term "independent" shall be the standard used by the State Board of Public Accountancy.

(b) Effective with report periods beginning on or after January 1, 1977, the requirements of subdivision (a) of this section shall apply to residential health care facilities operated by units of government of the State of New York heretofore exempt from the requirements of this section except that those medical facilities for which an annual reimbursement audit by a State agency is required by law shall be required to comply herewith effective with report periods beginning on or after January 1, 1978.

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86-2.6 Certification by operator or officer. (a) The financial and statistical reports shall be certified by the operator of a proprietary medical facility, an officer of a voluntary medical facility or the public official responsible for the operation of a public medical facility.

(b) The form of the certification required in subdivision (a) of this section shall be as prescribed in the annual fiscal and statistical reports forms provided by the State Commissioner of Health.

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86-2.7 Audits. (a) All fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports, filed by the residential health care facility with the department, shall be kept and maintained by the facility for a period of time not less than six years from the date of filing, or the date upon which the fiscal and statistical records were to be filed, whichever is the later date. In this respect, any rate of payment certified by the State Commissioner of Health based on the initial submission of base year data and reports will be construed to represent a provisional rate until such audit is performed and completed, at which time such after or adjusted rate will be construed to represent the audited rate.

(b) Subsequent to the filing of required fiscal and statistical reports, field audits shall be conducted by the records of residential health care facilities, in a time, manner and place to be determined by the State Department of Health.

(c) The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department or from the date when due, whichever is later. This limitation shall not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this section.

(d) Upon completion of the audit the residential health care facility shall be afforded a closing conference. The residential health care facility

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may appear in person or by anyone authorized in writing to act on behalf of the residential health care facility. The residential health care facility shall be afforded an opportunity at such conference to produce additional documentation in support of any modifications requested in the audit.

(e) The residential health care facility shall be provided with the audit report and the rate computation sheet per audit. The audit report shall be final unless within 30 days of receipt of the audit report, the residential health care facility initiates a bureau review by notifying the Division of Health Care Financing by registered or certified mail, detailing the specific items of the audit report with which the provider disagrees and such other material as the provider wishes to submit in its behalf and forwarding all material documentation in support of the residential health care facility's position.

(f) The residential health care facility shall be notified in writing of the determination of the controverted items of the final audit report, including a statement of the reasons for such adjustments and the appropriate citation to applicable law, regulation or policy. The audit finding as adjusted in accordance with the determination of the bureau review shall be final, except that the residential health care facility may, within 30 days of receipt of the determination of the bureau review, initiate a hearing to refute those items of the audit report adverse to the interests of the residential health care facility presenting a factual issue by serving on the commissioner, by certified or registered mail, a notice containing a statement

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of the legal authority and jurisdiction under which the hearing should be held, a reference to the particular sections of the statutes and rules involved and a statement of the controverted items of the audit report and bureau determination, together with copies of any documentation relied on by the residential health care facility in support of its position.

(1) Upon receipt of such notice the commissioner shall:

(i) designate a hearing officer to hear and recommend;

(ii) establish a time and place for such hearing;

(iii) notify the residential health care facility of the time and place of such hearing at least 15 days prior thereto; and

(iv) include in a notice of hearing those issues of the audit report which are controverted in the notice served on the commissioner by the residential health care facility.

(2) The issues and documentation presented by the residential health care facility at such hearing shall be limited to the factual issues and documentation presented at the bureau review.

(3) The audit report shall be presumptive evidence of its content. The burden of proof at any such hearing shall be upon the residential health care facility to prove by substantial evidence that the items therein contained are incorrect. At such hearing, the residential health care facility shall have the obligation to initially present such evidence in support of its position. Failure to do so shall result in termination of the hearing.

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(4) The hearing shall be conducted in conformity with section 12-a of the Public Health Law and State Administrative Procedure Act.

(5) At the conclusion of the hearing the residential health care facility may submit memoranda on any legal issues which it deems relevant to the proceeding. Such memoranda shall become part of the official record of the hearing.

(g) Rate revisions resulting from the procedure set forth in this section shall be made retroactive to the period or periods during which the rates based on the periods audited were established. Any resulting overpayment or underpayment shall be satisfied by either retroactive adjustment of the provisional rate paid based on the period audited, or prospective adjustment of the current certified rate at the discretion of the State Commissioner of Health.

(h) All overpayments resulting from rate revisions shall be subject to such penalties as the Commissioner of Health may impose for incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions. The penalties assessed under this section are separate from and shall not be construed to be in mitigation of damages which may be recovered pursuant to section 145-b of the Social Services Law.

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86-2.8 Patient days. (a) A patient day is the unit of measure denoting lodging provided and services rendered to one patient between the census-taking hour on two successive days.

(b) In computing patient days, the day of admission shall be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes residential health care facility days shall be determined by using the higher of the minimum utilization factor of 90 percent of certified beds or the actual patient days of care as furnished by the facility.

(d) Reserved bed patient days shall be computed separately from patient days. A reserved bed patient day is the unit of measure denoting an overnight stay away from the residential health care facility for which the patient, or patient's third-party payor, provides per diem reimbursement when the patient's absence is due to hospitalization or therapeutic leave.

(e) In computing reserved bed patient days, the day of discharge from the residential health care facility shall be counted, but not day of readmission.

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The voluntary health care facility right-sizing program is intended to address excess capacity in residential health care facilities. Under this program, a residential health care facility may apply to temporarily decertify, or permanently convert, a portion of its existing certified beds to another level of care. The Commissioner of Health may approve temporary decertification and permanent bed conversions, which total no more than [2,500] 5,000 residential health care beds on a statewide basis.

A residential health care facility may temporarily decertify beds for up to five years. Temporarily decertified beds will remain on the facility's license during and after the five-year period.

The following adjustments to the calculation of Medicaid rates of payment for residential health care centers will be made for facilities that have temporarily decertified beds under this program:

- Capital cost reimbursement will be adjusted to reflect the new bed capacity;
- The facility's peer group assignment for indirect cost reimbursement will be based upon total certified beds less the number of temporarily decertified beds; and
- The facility's vacancy rate, for the purpose of determining eligibility for reserved bed day payments, will be calculated on the basis of the facility's total certified beds less the number of temporarily decertified beds. Payments for reserved bed days for facilities that have temporarily decertified beds will be in an amount that is fifty percent of the otherwise applicable payment amount for such beds.

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86-2.10 Computation of basic rate. (a) Definitions. For purposes of this Title, the following definitions shall apply:

(1) Direct price shall mean the monetary amount established for the direct component of the rate, based on the direct costs of all facilities after application of the regional direct input price adjustment factor, divided by patient days and the average statewide case mix index.

(2) Indirect price shall mean the monetary amount established for the indirect component of the rate, based on the indirect costs for each facility in a peer group, after application of a regional indirect price adjustment factor, divided by total peer group patient days.

(3) Peer group shall mean a set of facilities distinguished by like characteristics which are grouped for purposes of comparing costs and establishing payment rates using such criteria as affiliation (i.e., hospital-based or freestanding) case mix index (i.e., high intensity, case mix index greater than .83, or low intensity, case mix index less than or equal to .83), and size (i.e., less than 300 beds or 300 or more beds).

(4) Cost center shall mean categories into which related costs are grouped in accordance with and defined in Part 455 of this Title.

(5) Case mix index shall mean the numeric weighting of each patient classification group in terms of relative resource utilization as specified in Appendix 13-A, *infra*.

(6) Rate shall mean the aggregate governmental payment to facilities per patient day as defined in section 86-2.8 of this Subpart, for the care

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of medicaid patients which shall include a Direct, Indirect Non-Comparable and Capital component.

(7) Operating portion of the rate shall mean the portion of the rate consisting of the Direct, Indirect and Non-Comparable components after application of the roll factor promulgated by the department.

(8) Role Factor shall mean the cumulative result of multiplying one year's trend (inflation) factor times one or more other years trend factor(s) which is used to inflate costs from a base period to a rate period.

(9) Capital Costs shall mean costs reported in the Depreciation, Leases and Rentals, Interest on Capital Debt and/or Major Movable Equipment Depreciation Cost Centers, as well as costs reported in any other cost center under the major natural classification of Depreciation, Leases and Rentals on the facilities annual cost report (PHCF-4).

(10) Base shall mean, as applicable to cost or price, a minimum cost or price.

(11) Ceiling shall mean, as applicable to cost or price, a maximum cost or price.

(12) Corridor shall mean the difference between a base and a ceiling.

(13) Hospital based shall mean as follows:

(i) For facilities receiving initial operating certificates prior to January 1, 1983, hospital based shall mean those facilities that are considered by the federal Health Care Financing

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Administration (HCFA) to be hospital based or hospital rated (as pertaining to cost allocation) and which derive and report costs on the basis of a Medicare cost allocation methodology from an affiliated hospital.

- ii. For facilities receiving operating certificates after January 1, 1983 the Commissioner shall review and determine whether or not such facilities are hospital based utilizing the following criteria:
  - a. the nature of any construction approval received pursuant to Section 2802 of the Public Health Law;
  - b. the nature of any establishment approval received pursuant to Section 2801-a of the Public Health Law;
  - c. the architectural configuration for the residential health care facility unit as related to the hospital physical plant;
  - d. the method and amount of cost allocation;
  - e. whether a determination that such a facility is hospital based would result in the efficient and economic operation of such facility.

(b) (1) The rate for 1986 and subsequent rate years shall

- i. be computed on the basis of allowable fiscal and statistical data submitted by the facility for the fiscal year ending December 31, 1983, as contained in parts I, II, III and IV of the facility's annual cost report (RHCF-4) and for hospital based facilities, the annual cost report (RHCF-2) and the institutional cost report of its related hospital. Beginning with the annual cost report filed for 2005 and for each year thereafter, in the event the operating costs reported by a facility are less than 90 percent of the operating costs reported in the cost report utilized to compute the facility's rates, trended to 2005 and each year thereafter, the facility's rates shall be recalculated utilizing the more recent reported operating cost data.

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(ii) Consist of the following four separate and distinct components, as defined in this section.

(a) Direct

(b) Indirect

(c) Non-Comparable

(d) Capital

(2) The operating portion of the rate for 1986 and subsequent rate years shall consist of the sum of the Direct, Indirect and Non-Comparable Components of the rate determined in accordance with this section trended to the rate year by the applicable roll factor promulgated by the department.

(3) Allocation and Adjustments of Reported Costs.

(i) The computation of the rate for 1986 and for subsequent rate years shall incorporate the use of the single stepdown method of cost allocation as defined in section 451.249 of Article 9 of Subchapter A of Chapter V of this Title.

(ii) Individual discrete ceilings shall be applied to remuneration for the facility's administrator, assistant administrator and operator as specified in Appendix 6a infra.

(iii) Reported Costs of 1983 shall be adjusted through the apportionment of retroactive adjustments due to operating appeals which were as a result of significant increases in staff specifically mandated by the Commissioner. Such adjustments shall be limited to

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those related to staff hired subsequent to December 31, 1982 and those appeal requests received by the department prior to July 1, 1985.

(iv) In the determination of rates, reported costs shall be subject to the limitations and adjustments contained in sections 86-2.12, 86-2.17, 86-2.18, 86-2.25 and 86-2.26 of this Subpart.

(v) Salaries paid to related parties shall be subject to an initial maximum not to exceed \$17,000. This limitation may be waived by the department pursuant to the provisions of section 86-2.14(a)(7) of this Subpart.

(c) **Direct component of the rate.** (1) Allowable costs for the direct component of the rate shall include costs reported in the following functional cost centers on the facility's annual cost report (RHCF-4) or extracted from a hospital-based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending.

- (i) nursing administration;
- (ii) activities;
- (iii) social services;
- (iv) transportation;
- (v) physical therapy;
- (vi) occupational therapy;
- (vii) laundry and linen

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- ~~[(viii)]~~ (vii) speech and hearing therapy-(speech therapy portion only)
- ~~[(ix)]~~ (viii) pharmacy;
- ~~[(x)]~~ (ix) central service supply; and
- ~~[(xi)]~~ (x) residential health care facility.

(2) For purposes of calculating the direct component of the rate, the department shall utilize the allowable direct costs reported by all facilities with the exception of specialty facilities as defined in subdivision (1) of this section.

(3) [Except as provided for in subparagraph (4)(viii) of this subdivision, the] The statewide mean, base and ceiling direct price for patients in each patient classification group shall be determined as follows:

(i) Allowable costs for the direct cost centers for each facility after first deducting capital costs and items not subject to trending, shall be multiplied by the appropriate Regional Direct Input Price Adjustment Factor ("RDIPAF"), as determined pursuant to paragraph (5) of this subdivision. The RDIPAF neutralizes the difference in wage and fringe benefit costs between and among the regions caused by differences in the wage scaled of each level of employee.

(ii) The statewide distribution of patients in each patient classification group shall be determined for 1986 payments utilizing

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the patient data obtained in the patient assessment period, March 1, 1985 through September 30, 1985, conducted pursuant to Section 86-2.30 of this Subpart.

(iii) A statewide mean direct case mix neutral cost, a statewide base direct case mix neutral cost and a statewide ceiling direct case mix neutral cost shall be determined as follows:

(a) Allowable direct costs for each facility, after first deducting capital costs and items not subject to trending and adjusted by applying the RDIPAF shall be summed to determine total statewide direct costs.

(b) The aggregate statewide case mix index shall be determined by multiplying number of patients on a statewide basis in each patient classification group by the case mix index for each patient classification group and the results summed.

(c) A statewide mean direct cost per day shall be determined by dividing total statewide direct costs by the aggregate number of statewide 1983 patient days.

(d) A statewide mean direct case mix neutral cost per day shall be determined by dividing the statewide mean direct cost per day by the ratio of the aggregate statewide case mix index to the number of patient review instruments received pursuant to Section 86-2.30 of this Subpart.

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(e) The statewide mean direct case mix neutral cost per day shall be the basis to establish a corridor between the statewide base direct case mix neutral cost per day and the statewide ceiling direct case mix neutral cost per day.

(f) The corridor shall be established by use of a base factor and a ceiling factor expressed as a percentage of the statewide mean direct case mix neutral cost per day.

(g) A statewide base direct case mix neutral cost per day shall be determined by multiplying the base factor times the statewide mean direct case mix neutral cost per day.

(h) A statewide ceiling direct case mix neutral cost per day shall be determined by multiplying the ceiling factor times the statewide mean direct case mix neutral cost per day.

(i) A statewide mean direct price per day for each patient classification group shall be determined by multiplying the statewide mean direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

(j) A statewide base direct price per day for each patient classification group shall be determined by multiplying the statewide base direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

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(k) A statewide ceiling direct price per day for each patient classification group shall be determined by multiplying the statewide ceiling direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

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(1) The corridor referred to in clause (e) of this subparagraph shall be calculated as follows:

(1) The base factor referred to in clause (f) of this subparagraph shall be approximately 90 percent effective January 1, 1996 and thereafter. The base factor referred to in clause (f) of this subparagraph shall be approximately 90 percent for the period January 1, 1987 through December 31, 1987, such factor shall be approximately 90 percent. For the period January 1, 1988 through December 31, 1992, such factor shall be increased to approximately 95 percent. For the period January 1, 1993 through December 31, 1995 such factor shall be approximately 90 percent.

(2) The ceiling factor referred to in clause (f) of this subparagraph shall be approximately 115 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987 such factor shall be reduced to approximately 110 percent. For the period January 1, 1988 through December 31, 1988, and thereafter such factor shall be reduced to approximately 105 percent.

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(iii) For the period January 1, 1985 through December 31, 1986, the base factor and ceiling factor contained in this clause shall initially be determined to result in a 20 percent corridor. The ceiling factor shall then be increased by 5 percent. For the period January 1, 1987 through December 31, 1987, the application of the base factor and ceiling factor contained in this clause shall result in a 20 percent corridor. For the period January 1, 1988 through December 31, 1988, and thereafter, the base factor and ceiling factor contained in this clause shall result in a 10 percent corridor.

(4) The facility specific direct adjusted payment price per day shall be determined as follows:

(i) The facility specific mean direct price per day shall be determined by multiplying the statewide mean direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(ii) The facility specific base direct price per day shall be

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determined by multiplying the statewide base direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(iii) The facility specific ceiling direct price per day shall be determined by multiplying the statewide ceiling direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(iv) The facility specific cost based direct price per day shall be determined by dividing a facility's adjusted allowable reported direct costs after first deducting capital costs and items not subject to trending and, after application of the RPIRAF, by the facility's 1983 total patient days.

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(v) Except as contained in subparagraph (vi) of this paragraph, the facility specific direct adjusted payment price per day shall be determined by comparison of the facility specific cost based price per day with the facility specific base direct price per day and the facility specific ceiling direct price per day pursuant to the following table:

<u>Facility Specific Cost Based</u> <u>Direct Price Per Day</u>	<u>Facility Specific Direct</u> <u>Adjusted Payment Price Per Day</u>
<u>Below Facility Specific Base</u> <u>Direct Price Per Day</u>	<u>Facility Specific Base</u> <u>Direct Price Per Day</u>
<u>Between Facility Specific Base</u> <u>Direct Price Per Day and Facility</u> <u>Specific Ceiling Direct</u> <u>Price Per Day</u>	<u>Facility Specific Cost</u> <u>Based Direct Price Per Day</u>
<u>Above Facility Specific Ceiling</u> <u>Direct Price Per Day</u>	<u>Facility Specific Ceiling</u> <u>Direct Price Per Day</u>

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(vi) The facility specific direct adjusted payment price per day shall be considered to be the facility specific cost based direct price per day when such price is below the facility specific base direct price per day subject to the provisions of paragraph 5 of this subdivision for the following operators of residential health care facilities:

(a) An operator who has had an operating certificate revoked pursuant to Section 2806(5) of the Public Health Law and is operating a residential health care facility pursuant to an Order of the Commissioner of this department;

(b) An operator of a facility in which the federal Health Care Financing Administration (HCFA) has imposed a ban on payment for all Medicare and Medicaid admissions after a specified date pursuant to Section 1355(f) of the federal Social Security Act until the lifting of the ban in writing by HCFA.

(vii) The direct component of a facility's rate shall be the facility specific direct adjusted payment price per day determined in subparagraph (v) or (vi) of this paragraph as applicable after applying the RDIPAF.

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(5) The RDIPAF shall be based on the following factors:

(i) Residential health care facilities shall be grouped, by county, into 16 regions within the State as outlined in Appendix 13-A, infra.

(ii) The [facilities] facility's staffing, based on case mix predicted staffing for registered professional nurses, licensed practical nurses, and aides, orderlies and assistants for each facility. The case mix predicted staffing shall be adjusted annually on January 1st of each rate year based on the [most recent] PRI's submitted by each facility [prior to January 1st] for the fourth quarter of the preceding calendar year, in accordance with sections 86-2.11(b) and 86-2.30 of this Subpart. Until such PRIs are available, the case mix predicted staffing shall be based on the most current PRIs available prior to calculation of the initial rate effective January 1st of each rate year. The case mix predicted staffing shall subsequently be revised based on more recent PRI submissions until such time as the PRIs for the fourth quarter of the preceding calendar year are available.

(iii) The proportion of salaries and fringe benefit costs for the direct care cost[s] centers indicated in subdivision (c) of this section to the total costs of such direct care cost centers.

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(6) Case mix adjustment. A facility shall receive an increase or decrease in the direct component of its rate if the facility has increased or decreased its case mix from one assessment period to the next and, in accordance with subparagraph (v) of paragraph (4) of this subdivision, would not have received any change in the direct component of its rate from that determined as of January 1, 1986 to the current calculation date. The increases or decreases in the direct component of the rate shall be determined as follows:

(i) The facility specific mean price per day effective January 1, 1986 as determined in accordance with section 86-2.10(4)(i) shall be compared to the facility specific mean price per day determined as a result of the submissions required in accordance with section 86-2.11(b) of this subpart. Any increase or decrease determined as a result of such comparison, shall be expressed as a percentage, positive or negative, of the facility specific mean price per day effective January 1, 1986.

(ii) This percentage shall be applied to the Facility Specific Cost Based Direct Price Per Day determined as of January 1, 1986 and an adjustment factor shall be determined.

(iii) This adjustment factor shall be added to or subtracted from the facility specific cost based direct price per day determined as of January 1, 1986, to arrive at an adjusted facility specific cost based direct price per day which shall become for a facility

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their facility specific adjusted payment price per day for applicable rate period for which payment rates are adjusted pursuant to section 86-2.11 of this Subpart.

(d) **Indirect component of the rate.**

(1) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's annual cost report (RHCF-4) or extracted from a hospital based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending:

(i) fiscal services;

(ii) administrative services;

(iii) plant operations and maintenance (with the exception of utilities and real estate and occupancy taxes);

(iv) grounds;

(v) security;

(vi) laundry and linen;

~~[(vi)]~~ (vii) housekeeping;

~~[(vii)]~~ (viii) patient food services;

~~[(viii)]~~ (ix) cafeteria;

~~[(ix)]~~ (x) non-physician education;

~~[(x)]~~ (xi) medical education;

~~[(xi)]~~ (xii) housing; and

~~[(xii)]~~ (xiii) medical records.

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For the purposes of establishing the indirect component of the rate of payment for services provided on or after April 1, 1995 through March 31, 1999 and for services provided on or after July 1, 1999 through [March] December 31, 2006, the reimbursable base year costs as reported in the fiscal services and administrative services functional cost centers as specified in subparagraphs (i) and (ii) of this paragraph of a provider of services, excluding a provider of services reimbursed on an initial budget basis, shall not, except as otherwise provided in this paragraph, exceed the statewide average of total reimbursable base year administrative and fiscal service costs. For the purposes of this paragraph, reimbursable base year administrative and fiscal service costs shall mean those base year administrative and fiscal services costs remaining after application of all other efficiency standards, including but not limited to, peer group ceilings or guidelines. Effective for rates of payment commencing July 1, 2000, a separate statewide average of total reimbursable base year administrative and fiscal services costs shall be determined for each of those facilities wherein eighty percent or more of its patients are classified with a patient acuity equal to or less than .83 which is used as the basis for a facility's case mix adjustment. For the period July 1, 2000 through March 31, 2001, the total reimbursable base year administrative and fiscal services costs of such facilities shall not exceed such separate statewide average plus one and one-half percentage points. For annual periods thereafter through [March] December 31, 2006, the total reimbursable base year administrative and fiscal services costs of such facilities shall not exceed such separate statewide average. In no event shall the calculation of this separate statewide average result in a change in the statewide average determined pursuant to this paragraph. The limitation on reimbursement for provider administrative and general expenses provided by this paragraph shall be expressed as a percentage reduction of the operating cost component to the rate promulgated for each residential health care facility.

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(2) For the purposes of establishing the allowable indirect component of the rate, facilities shall be combined into peer groups as follows:

(i) Size:

(a) less than 300 beds;

(b) 300 or more beds

(ii) Affiliation:

(a) free-standing;

(b) hospital-based.

(iii) Case mix index:

(a) high intensity, case mix index greater than .83;

(b) low intensity, case mix index less than or equal to .83.

(3) If any peer group contains fewer than five facilities, those facilities shall be included in a peer group of a similar type.

(4) For each of the peer groups, the indirect component of the rate shall be determined as follows:

(i) A mean indirect price per day shall be computed as follows:

(a) Reported allowable costs for the indirect cost centers for each facility in the peer group, after first deducting capital costs and allowable items not subject to trending shall be adjusted by applying the Regional Indirect Input Price Adjustment Factor ("RIIPAF"), as determined pursuant to paragraph (6) of this subdivision.

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(b) The results of the calculation in clause (a) of this subparagraph shall be aggregated and divided by total 1983 patient days of all facilities in the peer group.

(ii) The mean indirect price per day shall be the basis to establish a corridor between the base indirect price per day and the ceiling indirect price per day. The corridor shall be established by use of a base factor and a ceiling factor expressed as a percentage of the mean indirect price per day.

(a) The base factor shall be approximately 90 percent effective January 1, 1996 and thereafter. The base factor shall be approximately 90 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, such factor shall be increased to approximately 95 percent. For the period January 1, 1988 through December 31, 1992, such factor shall be increased to approximately 97.5 percent. For the period January 1, 1993 through December 31, 1995 such factor shall be approximately 92.5 percent.

(b) The ceiling factor shall be approximately 110 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, and thereafter, such factor shall be reduced to approximately 105 percent.

(iii) For the period January 1, 1986 through December 31, 1986, the base factor and ceiling factor contained in subparagraph (ii) of this paragraph, shall result in a 20 percent corridor. For the

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period January 1, 1987 through December 31, 1987, the base factor and ceiling factor contained in subparagraph (ii) of this paragraph shall result in a 10 percent corridor. For the period January 1, 1988 through December 31, 1988, and thereafter, the base factor and ceiling factor contained in subparagraph (ii) of this paragraph shall initially be determined to result in a five percent corridor. The ceiling factor shall then be increased by 2.5 percent.

(iv) The base indirect price per day shall be determined by multiplying the base factor times the mean indirect price per day.

(v) The ceiling indirect price per day shall be determined by multiplying the ceiling factor times the mean indirect price per day.

(vi) The facility specific indirect adjusted payment price per day shall be determined by comparison of a facility's adjusted reported indirect costs after deducting capital costs and items not subject to trending and after application of the RIIPAF, divided by the facility's total 1983 patient days, with the base indirect price per day and the ceiling indirect price per day. Except as outlined in subparagraph (vii) of this paragraph, the facility specific indirect adjusted payment price per day shall be established as presented by the following table:

Facility Adjusted Costs Divided by Patient Days	Facility Specific Indirect Adjusted Payment Price Per Day
<u>Below Base Indirect Price Per Day</u>	<u>Base Indirect Price Per Day</u>
<u>Between Base Indirect Price Per Day and Ceiling Indirect Price Per Day</u>	<u>Reported Adjusted Costs Per Day</u>
<u>Above Ceiling Indirect Price Per Day</u>	<u>Ceiling Indirect Price Per Day</u>

(vii) The facility specific indirect adjusted payment price per day shall be considered to be the facility specific cost based indirect price per day when such price is below the facility specific base indirect price per day for the following operations of residential health care facilities:

(a) An operator who has had an operating certificate revoked pursuant to Section 2806(5) of the Public Health Law and is operating a residential health care facility pursuant to an Order of the Commissioner of this department;

(b) An operator of a facility in which the Federal Health Care Financing Administration (HCFA) has imposed a ban on payment for all Medicare and Medicaid admissions after a

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specified date pursuant to section 1866(F) of the Federal Social Security Act until the lifting of the ban in writing by HHS.

(5) For each rate year, a facility's indirect costs shall be compared to the peer groups identified in paragraph (2) of this subdivision as follows:

(i) A facility's peer group established pursuant to paragraphs (2)(i) and (ii) of this subdivision shall be based on that facility's affiliation status prior to the effective rate period, contingent upon the provisions of section 86-2.34 of this Subpart, and total certified bed capacity listed on the operating certificate.

(ii) Those facilities having 80% or more of all patients falling into patient classification groups with weights greater than .83 shall be compared to the peer group established pursuant to clause (a) of subparagraph (iii) of paragraph (2) of this subdivision.

(iii) Those facilities having 80% or more of all patients falling into patient classification groups with weights equal to or less than .83 shall be compared to the peer group established pursuant to clause (b) of subparagraph (iii) of paragraph (2) of this subdivision.

(iv) Those facilities who do not meet either of the above conditions identified in subparagraphs (ii) and (iii) of this paragraph, shall be compared to a blended peer group mean price per day. Such price shall be determined by blending the number of a facility's patients which have patient classification group weights above .83 at the high intensity peer group mean price and the number of a facility's patients at or below .83 at the low intensity peer group mean price as defined pursuant to paragraph (4) of this subdivision.

(v) The peer group mean price effective January 1st of each rate year shall be based on the PRIs submitted by each facility for the fourth quarter

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of the preceding calendar year in accordance with 86-2.11(b) and 86-2.30 of this Subpart. Until such PRIs are available, the peer group mean price shall be based on the most current PRIs available prior to calculation of the initial rate effective January 1st of each rate year. The peer group mean price shall subsequently be revised based on more recent PRI submissions until such time as the PRIs for the fourth quarter of the preceding calendar year are available.

[(5)] (6) The indirect component of a facility's rate shall be the facility specific indirect adjusted payment price per day determined in accordance with subparagraphs (vi) and (vii), as applicable of paragraph (4) of this subdivision after application of the RIIPAF.

[(6)] (7) The RIIPAF shall be based on the following factors:

[(a)] (i) residential health care facilities shall be grouped by county, into 16 regions within the State as outlined in Appendix 13(b) infra.

[(b)] (ii) the facility's staffing, based on case mix predicted staffing for registered professional nurses, licensed practical nurses, and aides, orderlies and assistants for each facility. The case mix predicted staffing shall be adjusted annually on January 1st of each rate year based on the [most recent] PRI's submitted by each facility [prior to January 1st], for the fourth quarter of the preceding calendar year, in accordance with sections 86.2.11(b) and 86-2.30 of this Subpart. Until such PRIs are available, the case mix predicted staffing shall be based on the most current PRIs available prior to calculation of the initial rate effective January 1st of each rate year. The case mix predicted staffing shall subsequently be revised based on more recent PRI submissions until such time as the PRIs for the fourth quarter of the preceding calendar year are available; and

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[(c)] (iii) the proportion of salaries and fringe benefits costs for the indirect care cost centers indicated in paragraph 1 of this subdivision to the total costs of such indirect care cost centers.

(e) Gain or Loss Limitation for the Direct and Indirect Component of the Rate:

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Gain or losses resulting from using the Regional direct or indirect input price adjustment factors rather than individual facility specific direct or indirect input price adjustment factors shall be determined as follows:

(1) A facility's allowable direct costs divided by the facility's 1983 total patient days shall be compared to the facility's direct component and a direct gain or loss per day calculated.

(2) A facility's allowable indirect costs divided by the facility's 1983 total patient days shall be compared to the facility's indirect component and an; indirect gain or loss per day calculated.

(3) The facility's direct gain or loss per day and indirect gain or loss per day shall be summed to arrive at a facility's net composite gain or loss per day.

(4) If a facility's net composite gain or loss per day is greater than \$3.50, for the rate year 1986, a limitation shall be applied for rate years 1986 through 1989 as follows:

(i) For 1986 rates, if a facility has a net composite gain, then a facility's direct or indirect cost per day shall be determined by utilizing the Regional or the individual facility specific input price adjustment factor, which ever factor when applied would reduce the gain.

(ii) For 1986 rates, if a facility has a net composite loss, then a facility's direct or indirect cost per day shall be determined by utilizing the Regional or the individual facility specific input price adjustment factor, whichever factor, when applied, would reduce

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(iii) If a facility's direct or indirect cost per day is determined, pursuant to subparagraph (i) or (ii) of this paragraph, by utilizing the Regional input price adjustment factor, such factor shall be utilized in all subsequent rate years.

(iv) If a facility's direct or indirect cost per day is determined, pursuant to subparagraph (i) or (ii) of this paragraph, by utilizing the individual facility specific input price adjustment factor, the following shall apply to subsequent rate years:

(a) For 1987 rates, a facility's direct or indirect cost per day shall be determined by using a composite of 50% of the Regional and 50% of the facility specific input price adjustment factor.

(b) For 1988 rates, a facility's direct or indirect costs per day shall be determined by using a composite of 75% of the Regional and 25% of the facility specific input price adjustment factor.

(c) For 1989 and subsequent rate years, a facility's direct costs per day shall be determined by using the Regional input price adjustment factors.

(5) The limitations of this subdivision shall not be applicable to specialty facilities as defined in subdivision (ii) of this section.

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(f) Non-Comparable Component of the Rate:

(1) The non-comparable component of the rate shall consist of costs which represent allowable costs reported by a facility which because of their nature are not subject to peer group comparisons.

(2) Allowable costs for the non-comparable component of the rate shall include the costs associated with supervision of facility volunteers and costs reported in the following functional cost centers as reported on the facility's annual cost report (RHCF-4) or extracted from a hospital based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting capital cost and allowable items not subject to trending:

- i. Laboratory Services
- ii. ECG
- iii. EEG
- iv. Radiology
- v. Inhalation Therapy
- vi. Podiatry
- vii. Dental
- viii. Psychiatric
- ix. Speech and Hearing Therapy - (Hearing Therapy Only)
- x. Medical Director Office
- xi. Medical Staff Services

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xii. Utilization Review

xiii. Other Ancillary

xiv. Plant Operations and maintenance - (cost for  
facilities and real estate and occupancy taxes  
only).

(3) The allowable facility specific non-comparable component of the rate shall be reimbursed at a payment rate equal to adjusted reported non-comparable costs, after first deducting capital costs and allowable items not subject to trending, divided by the facility's total 1983 patient days.

(g) Capital Component of the Rate. The allowable facility specific capital component of the rate shall include allowable capital costs determined in accordance with section 86-2.19, 86-2.20, 86-2.21 and 86-2.22 of this Subpart and costs of other allowable items determined by the department to be non-trendable divided by the facility's patient days in the base year determined applicable by the department.

(h) A facility's payment rate for 1986 and subsequent rate years shall be equal to the sum of the operating portion of the rate as defined in paragraph (2) of subdivision (b) of this section and the capital component as defined in subdivision (g) of this section.

(i) Specialty Facilities. Facilities which provide extensive nursing, medical, psychological and counseling support services to children with diverse and complex medical, emotional and social problems shall be considered

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specialty facilities and shall not be subject to the provisions of paragraphs (c)(3), (c)(4), (d)(4), (d)(5), and (d)(6) of this section. The direct component of such facilities' rates shall be calculated based on allowable 1983 direct costs as defined in paragraph (c)(1) of this section, divided by the facilities' total 1983 patient days. The indirect component of such facilities' rates shall be calculated based on allowable 1983 indirect costs as defined in paragraph (d)(1) of this section, divided by the facilities' total 1983 patient days.

(k) Receiverships and new operators. (1) The appointment of a receiver or the establishment of a new operator to an ongoing facility shall require such receiver or operator to file a cost report for the first [six-month] twelve-month period of operation in accordance with section 86-2.2(e) of this Subpart. This report shall be filed and properly certified within 60 days following the end of the [six-month] twelve-month period covered by the report. Failure to comply with this subdivision shall result in [a reduction of the current rate in accordance with] application of the provisions of section 86-2.2(c) of this Subpart.

(2) The initial rate for facilities covered under this subdivision shall be the higher of (i) the rate in effect on the date of the appointment of a receiver or the date of transfer of ownership as applicable[,] or (ii) the rate in effect on the date of appointment of a receiver or the date of transfer of ownership as applicable with the direct and indirect component of such rate calculated as follows:

(a) The direct component of the rate shall be equivalent to the facility-specific mean direct price per day after application of the RDIPAF as determined in section 86-2.10(c) of this Subpart. The PRIs used in the computation of the facility-specific mean direct price per day shall be the PRIs used to calculate the rate in effect on the date of appointment of a receiver or the date of transfer of ownership.

(b) The indirect component of the rate shall be equivalent to the mean indirect price per day, determined using the PRIs used to calculate the rate in effect on the date of appointment of a receiver or date of transfer of ownership, and adjusted by the RIIPAF as determined in section 86-2.10(d) of this Subpart.

(3) The facility shall perform an assessment of all patients, pursuant to Section 86-2.30 of this subpart, at the beginning of the fourth month of operation. The direct component of the rate shall be adjusted pursuant to this subpart effective the first day of the assessment period based on the facility's case mix.

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(4) The twelve-month cost report referred to in paragraph (1) of this subdivision shall be used to adjust the direct, indirect, noncomparable and capital components of the rate effective on the first day of the twelve-month cost report period.

(5)(i) For purposes of this subdivision, and except as identified in paragraph (7) herein, the terms "new operator" and "receiver" shall not include any operator or receiver approved to operate a facility when:

- (a) a stockholder, officer, director, sole proprietor or partner of such operator or receiver was also a stockholder, officer, director, sole proprietor or partner of the prior operator or receiver of such facility;
- (b) the approved operator was the prior receiver of the facility;
- (c) any prior corporate operator or receiver is a corporate member of the approved operator or receiver, is otherwise affiliated with the approved operator or receiver through direct or indirect sponsorship or control or when the approved operator or receiver and prior operator or receiver are subsidiaries of a common corporate parent; or
- (d) a principal stockholder (owning 10 percent or more of the stock), officer, director, sole proprietor or partner of an approved proprietary operator or receiver is the spouse or child of a principal stockholder, officer, director, sole proprietor or partner of the prior operator or receiver of such facility, regardless of whether such relationship arises by reason of birth, marriage or adoption.

(ii) Rates of reimbursement for operators which are not considered new operators under this subdivision shall not be subject to adjustment under this subdivision.

(6) Notwithstanding the provisions of this subdivision, a receiver or new operator of a facility which has had an overall average utilization of at least 90 percent of bed capacity for a six-month period which began prior to April 1, 1993 but after the date on which the receiver was appointed or new operator became the operator shall submit a six-month cost report for that period. Such six-month cost report shall be utilized for the purpose[s] of this subdivision in lieu of the twelve-month cost report identified in paragraph (1) of this subdivision.

(7)(i) Notwithstanding the provisions of this subdivision, when a receiver of a proprietary nursing facility is appointed or a new operator of a previously established proprietary nursing facility is established and a stockholder, sole proprietor, partner or limited liability company member of such receiver or new operator is the child of a stockholder, sole proprietor, partner or member of the limited liability company of the prior operator or receiver of the facility, such receiver or new operator shall receive rates of reimbursement adjusted pursuant to paragraphs (1)-(4) and (6) of this subdivision. For

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purposes of this paragraph, child shall mean a child or stepchild by birth, adoption, or marriage. Rates of reimbursement for any subsequent operator of such facility who is established within 10 years of the date of appointment or establishment of such child or stepchild shall not be subject to adjustment under this subdivision.

(ii) For purposes of this paragraph, the terms "new operator" and "receiver" shall not include any operator or receiver with a stockholder, sole proprietor, partner, or limited liability company member who was a stockholder, sole proprietor, partner or limited liability company member of the prior operator or receiver of such facility.

(iii) For purposes of this paragraph, "new operator" shall also mean an established operator which has undergone a total change in owners, stockholders, partners or limited liability company members.

(iv) This paragraph shall apply to appointments of receivers and/or the establishment of a new operator on or after the effective date of this paragraph.

(l) Adjustments to the operating component of the rate.

(1) Notwithstanding any other provision of this section, the department shall make available the sum of \$10 million for rate year 1986 and \$5 million for rate year 1987, based on total system costs and total patient days, herein referred to as the transfer amount, to facilities in those rate years, whose reimbursement for the indirect component of their rates is less than their 1983 allowable costs for the indirect component of the rate, herein referred to as indirect losses.

(2) To determine eligibility for such adjustments, facilities shall also have suffered an aggregate loss. For purposes of this subdivision, an aggregate loss shall exist when a facility's composite 1983 allowable costs for the direct and indirect components.

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(1) Adjustments to the operating component of the rate.

(1) Notwithstanding any other provision of this section, the department shall make available the sum of \$10 million for rate year 1986 and \$5 million for rate year 1987, based on total system costs and total patient days, herein referred to as the transfer amount, to facilities in those rate years, whose reimbursement for the indirect component of their rates is less than their 1983 allowable costs for the indirect component of the rate, herein referred to as indirect losses.

(2) To determine eligibility for such adjustments, facilities shall also have suffered an aggregate loss. For purposes of this subdivision, an aggregate loss shall exist when a facility's composite reimbursement for the direct and indirect components of the rate is less than such a facility's composite 1983 allowable costs for the direct and indirect components.

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(3) The transfer amount referred to in paragraph (1) of this subdivision shall be made available by reductions in the operating components of facilities rates whose composite reimbursement for the Direct and Indirect Components of their rates is more than their composite 1983 allowable costs for the Direct and Indirect Components, herein referred to as aggregate gains.

(4) The transfer amounts referred to in paragraph (1) of this subdivision shall be distributed, for the applicable rate years, to eligible facilities by a per diem adjustment in the operating component of their rates in accordance with the following procedure:

(i) The indirect losses of all eligible facilities shall be summed to arrive at total indirect losses.

(ii) The proportion of a facility's indirect loss to total indirect losses shall be expressed as a percentage, herein referred to as a sharing percentage.

(iii) The sharing percentage for an eligible facility shall be multiplied by the transfer amount to arrive at a facility's share of the transfer amount.

(iv) A facility's share of the transfer amount shall be divided by 1983 patient days to arrive at a per diem adjustment to the operating component of a facility's rate.

(5) The transfer amounts referred to in paragraph (1) of this subdivision shall be accumulated from facilities referred to in paragraph (3) of this subdivision by a per diem adjustment to the operating component of their rates in accordance with the following procedure:

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(i) The aggregate gains of a facility shall be expressed as a percentage of their composite 1983 allowable costs for the Direct and Indirect Components. Such percentage shall be herein referred to as percentage gain.

(ii) The percentage gain for all facilities shall be ranked from highest to lowest.

(iii) A methodology shall be employed where, beginning with a set percentage, percentage gains in excess of such set percentage shall be noted, arrayed by facility and herein referred to as excess percentage gain.

(iv) The excess percentage gain shall be multiplied by each facility's allowable composite 1983 costs for the Direct and Indirect Components and such total for all facilities accumulated as a funded amount. The excess percentage gain shall also then be subtracted from a facility's percentage gain and the net percentage gain utilized as a facility's percentage gain for subsequent calculations.

(v) Such process shall continue, decreasing the set percentage used as a standard against which percentage gains of facilities is compared and the funded amounts accumulated until the transfer amounts referred to in paragraph (1) of this subdivision are realized.

(vi) If in this process, moving to the next set percentage used as a standard against which percentage gains of facilities is compared shall result in a total transfer amount in excess of the

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transfer amounts referred to in paragraph (1) of this subdivision, the following procedure shall be utilized to determine the amounts necessary to be funded by each facility in the final step of this process to attain the transfer amounts referred to in paragraph (1) of this subdivision:

(a) A facility's percentage gain shall be compared to the next lower set percentage that would be utilized as a standard and an excess percentage gain determined.

(b) The excess percentage gain for a facility, at that time, shall be multiplied by the facility's allowable composite 1983 costs for the direct and indirect components and the result herein referred to as an interim funded amount.

(c) The interim funded amount for each facility, expressed as a percentage of the aggregate of the interim funded amount for all facilities shall be multiplied by the remaining amount to be funded for a given rate year to arrive at a facility's portion of the final amount to be funded.

(vii) The funded amounts for a facility arrived at as a result of this paragraph shall be summed, divided by total 1983 patient days and deducted as a per diem adjustment from a facility's operating per diem in the appropriate rate year.

~~(m) Computation of regional input price adjustment factors applied for purposes other than determining, pursuant to this section, the statewide direct and peer group indirect prices.~~

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(1) The regional direct input price adjustment factor (RDIPAF) as contained in subparagraphs (c)(4)(iv) and (vii) of this section, the regional indirect input price adjustment factor (RIIPAF), as contained in subparagraph (d)(4)(vi) and paragraph (d)(5) of this section and the regional input price adjustment factor as contained in subparagraph (iv) of paragraph (4) of subdivision (e) of this section, hereinafter referred to as factors shall, be based on the regional average dollar per hour (RAP) calculated using the financial and statistical data required by §86-2.2 of this Subpart, reported solely for 1983 calendar year operations, adjusted as follows:

(i) RAP's shall be adjusted for the variation in wage and fringe benefit costs for each region relative to such variation for all other regions through the use of a variable corridor.

(ii) The measurement of the region's variation shall be accomplished by means of the statistical measure of variation, the coefficient of variation, in wage and fringe benefit costs.

(iii) The region with the smallest variation shall receive no corridor. The region with the highest variation shall receive a corridor no greater than a maximum percentage such that the average corridor for all regions in the State shall be approximately plus or minus 10 percent.

(iv) For rate years beginning on or after January 1, 1991, for those regions of the state described in Appendix 13-A, infra, whose Regional Average Dollar Per Hour (RAP), calculated using the financial and statistical data required by §86-2.2 of this Subpart reported solely for 1987 calendar year operations (1987 RAP) expressed as a percentage of the Statewide RAP for such year in greater than the percentage calculated using the same data reported for 1983 calendar year operations, (1983 RAP), the factors shall be determined utilizing 1987 RAPs and adjusted pursuant to subparagraph (i), (ii) and (iii) of this paragraph.

TN 04-24

App Date

SEP 28 2004

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95-07

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47(a)(1)

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SPA #04-24  
(04/04)

(a) Notwithstanding this subparagraph if the utilization of 1987 RAPS to determine the factors would, for any facility within a region described in this subparagraph, result in less reimbursement than the continued utilization of the 1983 RAPS to determine the factors, the factors utilized for such facility shall continue to be based on 1983 calendar year data.

(v) For purposes of establishing rates of payment by governmental agencies for residential health care facilities for services provided on and after January 1, 1998, the regional direct and indirect input price adjustment factors to be applied to any such facility's rate calculation shall be based upon the utilization of either 1983, 1987 or 1993 calendar year financial and statistical data. The determination of which calendar year's data to utilize shall be based upon a methodology that ensures that the particular year chosen by each facility results in a factor that yields no less reimbursement to the facility than would result from the use of either of the other two years' data. Such methodology shall utilize the 1983 and 1987 regional direct and indirect input price adjustment factor corridor percentages in existence on January 1, 1997 as well as 1993 regional direct and indirect input price adjustment factor corridor percentage calculated in the same manner as the 1983 and 1987 direct and indirect input price adjustment factor corridor percentages in existence on January 1, 1997.

(vi) For purposes of establishing rates of payment for residential health care facilities for services provided on and after April 1, 2004, the regional direct and indirect input price adjustment factors to be applied to any such facility's rate calculation shall be based upon the utilization of either 1983, 1987, 1993 or 2001 calendar year financial and statistical data provided, however, the total amount of rate increases attributable to the utilization of 2001 calendar year data shall be no more than \$47.5 million on a pro rata basis per calendar year. The determination of which calendar year's data to utilize shall be based upon a methodology that ensures that the particular year chosen by each facility results in a factor that yields no less reimbursement to the facility than would result from the use of the other three years' data. Such methodology shall utilize the 1983 and 1987 regional direct and indirect input price adjustment factor corridor percentages in existence on January 1, 1997, as well as the 1993 regional direct and indirect input price adjustment factor corridor percentage in existence on January 1, 2004, as well as a 2001 regional direct and indirect input price adjustment factor corridor percentage calculated in the same manner as the 1993 direct and indirect input price adjustment factor corridor percentage in existence on January 1, 2004.

TN 04-24

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47(b)

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(04/04)

(2) The corridor established in paragraph (1) of this subdivision shall be applied in each region as follows:

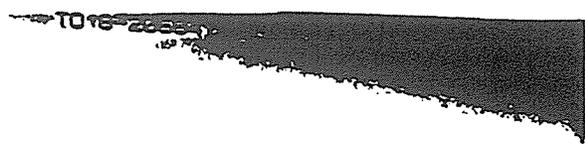
(i) The regional corridor percentage referred to in subparagraph (iii) of paragraph (1) of this subdivision, shall be applied, both negatively and positively to the RAP to arrive at an amount which when added to or subtracted from the RAP shall represent the maximum and minimum regional dollar per hour, for the region hereafter referred to as the maximum and minimum respectively.

(ii) The facility in each region with the highest facility wage and fringe benefit dollar per hour shall be assigned a facility RAP equivalent to the maximum.

(iii) The facility in each region with the lowest facility wage and fringe benefit dollar per hour shall be assigned a facility RAP equivalent to the minimum.

(iv) Facilities in a region with facility wage and fringe benefit dollars per hour between the highest and lowest facility wage and fringe benefit dollar per hour in such region shall be assigned a facility RAP on a sliding scale, based on the relativity of such facility's labor costs to the RAP and to the highest or lowest labor costs in the region, as applicable.

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(n) Long-term inpatient rehabilitation program for traumatic brain-injured residents (TBI).

[Adjustments to the operating portion of the rates for facilities] Facilities which have been approved to operate discrete units for the care of [patients] residents under the long-term inpatient rehabilitation program for [head-injured patients HI] TBI patients (established pursuant to section 416.11 of this Title) shall [be made] have separate and distinct payment rates for such units calculated pursuant to this section except as follows:

(1) In determining the facility-specific direct [adjustment] adjusted payment price per day pursuant to paragraph (c)(4) of this section for [patient] residents meeting the criteria for and residing in [the HI] a TBI unit, [separate and distinct statewide mean, base and ceiling prices shall be calculated and applied by multiplying the case mix proxy for such patients established by this subdivision times the statewide mean, base and ceiling direct case mix neutral cost per day, respectively.] the case mix index used to establish the statewide ceiling direct price per day for each patient classification group pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of this section for such residents shall be increased by an

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increment of 1.49. In determining the case mix adjustment pursuant to paragraph (6) of subdivision (c) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.49.

(a) The increment established in paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility's cost report submitted pursuant to this Subpart is less than the staffing pattern required by the Department to operate a TBI unit. A current period audit of current expenses may result in a negative adjustment to the increment on a prospective basis. An audit of prior period expenses may result in a retrospective negative adjustment to the increment.

(2) In determining the indirect component of a facility's rate pursuant to paragraphs (4), (5), and (6) of subdivision (d) of this section for residents meeting the criteria for and residing in a TBI unit, a facility's indirect costs shall be compared to the peer group established pursuant to clause (a) of subparagraph (iii) of paragraph (2) of subdivision (d) of this section.

(3) The noncomparable component of such facilities' rates shall be

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determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this [section] Subpart including approved actual costs in such cost report for personnel identified in required by ~~section 415.36~~ of this title Appendix 1 of this State Plan that would be reported in the functional cost centers identified in subdivision (f) of this section.

~~((4) The provisions of this subdivision will expire on December 31, 1994.~~

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(o)(1) [For rate year 1988,] A per diem amount of \$4.00 (subject

to adjustment pursuant to the provisions of paragraph (2) of this subdivision  
increased to the rate year by the projection factors determined pursuant to  
section 86-2.12 of this Subpart, adjusted by the RDIPAF[,], determined pursuant  
to paragraph (5) of subdivision (c) of this section, shall be added to each  
facility's payment rate for each patient whose primary medical problem, as  
reported in section V.29 of the patient review form (PRI) as contained in  
subdivision (i) of section 86-2.30 of this Subpart, is dementia, as defined in  
paragraph (4) of this subdivision, and who is properly assessed and reported by  
the facility in one of the following patient categories as listed in Appendix  
13-A of this Title:

Clinically Complex A

Behavioral A

Reduced Physical Functioning A

Reduced Physical Functioning B

(2) Based on the most current 1986 PRI's filed with the  
Department, the number of eligible dementia patient days [in 1988,] for Medicaid  
patients admitted prior to December 31, 1987, is estimated to be 1,750,000.  
Aggregate changes in such number in excess of 5% shall be deemed to be  
attributable to factors other than changes in patient condition and shall result  
in the recalculation and proportionate, prospective reduction of the per diem  
amount referred to in paragraph (1) of this subdivision.

(3) Facilities to whom the additional amount is paid shall  
demonstrate and document positive outcomes from implementation or continuation  
of programs and/or operations and promulgation of policies designed to improve  
the care of eligible dementia patients. The additional amount shall be recouped  
from facilities in which positive outcomes are not demonstrated.

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supercedes  
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01/01/89

(4) The per diem amount referred to in paragraph (1) of this subdivision shall be paid for any patients with the following dementia diagnoses. The dementia diagnosis and related codes and descriptions are taken from the International Classification of Diseases, 9th Revision, Clinical Modification, volume 3 (ICD-9-CM).

<u>ICD-9-CM Code</u>	<u>ICD-9-CM Diagnosis</u>
290.0	Senile dementia Uncomplicated senile dementia NOS, simple type excludes memory disturbance
290.1	Presenile dementia Brain syndrome with presenile brain disease Dementia in:  Alzheimer's disease Jakob-Croutzfeldt disease Pick's disease of the brain
290.10	Presenile dementia Uncomplicated presenile dementia NOS, simple type
290.11	Presenile dementia with delirium Presenile dementia with acute confusional state
290.12	Presenile dementia with delusional feature

- 290.13      Presenile dementia with depressive features
- 290.2       Senile dementia with delusional or depressive features
- 290.21      Senile dementia with depressive features
- 290.4       Multi-infarct dementia
- 290.40      Arteriosclerotic dementia
- 290.41      Arteriosclerotic dementia
- 290.42      Arteriosclerotic dementia
- 290.43      Arteriosclerotic dementia
- 294.0       Wernicke-Korsakoff syndrome (non-alcoholic)
- 293.81      Organic Brain Syndrome
- 294.8       Other specified organic brain syndrome
- 294.9       Unspecified organic brain syndrome
- 310.1       Organic personality syndrome
- 310.8       Other specified non-psychotic mental disorders, following  
              organic brain damage

- 310.9 Unspecified non-psychotic mental disorders following organic brain damage
- 331.0 Alzheimer's disease
- 331.1 Pick's disease
- 331.2 Senile degeneration of the brain
- 331.3 Communicating hydrocephalus
- 331.7 Cerebral degeneration in diseases classified elsewhere
- 331.8 Other cerebral degeneration
- 331.9 Cerebral degeneration, unspecified
- 331.89 Cerebral degeneration, NEC
- 333.4 Huntington's Chorea
- 437.0 Cerebral atherosclerosis

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3-6	2.67
7-8	2.84
9	3.23]

(a) In determining the direct component of a facility's rate pursuant to paragraphs (3) and (4) of subdivision (c) of this section for providing care for an AIDS patient in a residential health care facility designated as an AIDS facility or having a discrete AIDS unit, the case mix index for the AIDS patient shall be increased by an increment which shall be determined on the basis of the difference between allowable actual direct staffing levels and cost expenditures for the care of AIDS patients in specific patient classification groups and those of non-AIDS patients which are classified in the same patient classification groups based on data submitted by the facility. The increment to be included in a facility's rate shall be approved by the commissioner, but in no event shall the increment exceed 1.0. The facility's direct ceiling price shall be further increased by an occupancy factor of 1.089.

(b) For purposes of this [sub]paragraph, the allowable costs for the central service supply functional cost center as listed in paragraph (1) of subdivision (c) of this section shall be considered a non-comparable cost. [for an AIDS patient residing only in a discrete AIDS unit. These costs shall be initially determined based upon budget until the discrete unit operates six months at 80 percent occupancy at which time allowable costs shall be prospectively adjusted to actual costs.]

(ii) Except as identified in subparagraph (iii) of this paragraph, in [In] determining the indirect component of a facility's rate pursuant to paragraphs (4), (5), and (6) of subdivision (d) of this section for providing care for an AIDS patient in [an approved discrete AIDS unit] a residential health care facility designated as an AIDS facility or having a discrete AIDS unit, the peer group ceiling indirect [component of the rate] price shall be increased by [an AIDS] a factor of 1.20. [The AIDS factor for a specific facility shall be determined pursuant to the following formula:]

$$\left[ 1 + \left( \frac{\text{Number of approved discrete AIDS unit beds}}{\text{Total number of approved RHCF beds}} * 20\% \right) \right]$$

(iii) In determining the indirect component of a facility's rate pursuant to paragraphs (4) and (5) of subdivision (d) of this section for a facility with a total bed complement of less than 40 beds all of which are approved by the commissioner pursuant to Part 710 of this Title solely for the care and management of AIDS patients, the peer group ceiling indirect price shall be increased by a factor of 2.00 for those facilities that are less than or equal to 16 beds and such factor shall be decreased by 0.033 for every additional bed thereafter.

[(3)]

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APR 11 1994

Supersedes TN 90-10 Effective Date APR 1 - 1991

CORRECTED

New York  
47(j)

86-2.10 (90-10; 7/90)  
Attachment 4.19-D  
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- Deleted -

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CORRECTED

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47(k)

86-2.10 (90-10; 7/90)  
Attachment 4.19-D  
Part I

- Deleted -

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86-2.10 (6/91)  
Attachment 4.19-D  
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(3) (A cost report shall be filed in accordance with section 86-2.2 of this Subpart for the first six month period during which a new facility which has been certified for the purpose of providing services solely to AIDS patients has received an overall average utilization of at least 80 percent of bed capacity. This report shall be properly certified within 60 days

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JUL 11 1994.

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following the end of the six month period covered by the report. Failure to comply with this subparagraph shall result in a reduction of the current rate in accordance with subdivision (c) of section 86-2.2 of this Subpart.] For facilities which have received approval by the commissioner pursuant to Part 710 of this Title to provide services to a patient whose medical condition is HIV Infection Symptomatic, and the facility is not eligible for separate and distinct payment rates pursuant to paragraph (2) of this subdivision, the patient classification group case mix index for AIDS patients which is used to establish direct cost reimbursement shall be increased by an increment of 1.0.

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47(q)

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(q) Long term ventilator dependent residents. [Adjustments to the operating portion of rates for facilities] Facilities which have been approved to operate discrete units for the care of long-term ventilator dependent residents [as established pursuant to section 416.13 of this Title] shall [be made] have separate and distinct payment rates for such units calculated pursuant to this section except as follows:

(1) The facility specific direct adjusted price per day shall be determined as follows:

[(1)](a) In determining the facility specific direct adjusted payment price per day pursuant to paragraph (4) of subdivision (c) of this section for [patients] residents meeting the criteria [established in section 416.13 of this Title] and residing in a discrete unit for the care of long-term ventilator dependent [patients] residents, [separate and distinct statewide mean, base, and ceiling prices shall be calculated and applied by multiplying the case mix proxy for such patients established by this subdivision times the statewide mean, base, and ceiling direct case mix neutral cost per day respectively.] the case mix index used to establish the statewide ceiling direct price per day for each patient classification group pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of this section for such residents shall be increased by an increment of 1.15. In determining the case mix adjustment pursuant to paragraph (6) of subdivision (c) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.15.

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(b) The increments established in subparagraph (a) of paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility's cost report submitted pursuant to this Subpart is less than the staffing pattern required by the Department to operate a ventilator-dependent unit. A current period audit of current expenses may result in a negative adjustment to the increment on a prospective basis. An audit of prior period expenses may result in a retrospective negative adjustment to this increment.

(c) The allowable costs for the central service supply functional cost center as listed in paragraph (1) of subdivision (c) of this section shall be considered a noncomparable cost reimbursed pursuant to subdivision (f) of this section.

(d) The allowable costs for prescription drugs, specifically required by generally accepted standards of professional practice for long-term ventilator dependent residents, that are administered at a frequency and volume exceeding those of prescription drugs included in the direct component of the rate pursuant to subdivision (c) of this section shall be considered a noncomparable cost pursuant to subdivision (f) of this section.

[(2) For purposes of this subdivision, the case mix proxy solely for patients residing in a discrete unit for the care of long term ventilator dependent patients shall be defined as a case mix index of 2.52.]

(2) In determining the indirect component of a facility's rate pursuant to paragraphs (4), (5), and (6) of subdivision (d) of this section for residents meeting the criteria.

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and residing in a discrete unit for the care of long-term ventilator dependent residents, a facility's indirect costs shall be compared to the per group established pursuant to clause (d)(2)(iii)(a) of this section.

(3) The noncomparable component of such facilities' rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this [part] Subpart including approved actual costs in such cost report for personnel required by identified in ~~section 415.38 of this title~~ Appendix 2 of this State Plan that would be reported in the functional cost centers identified in subdivision (f) of this section.

~~((4) The provisions of this subdivision will expire on December 31, 1994.~~

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47(r)

(r) Nursing salary adjustment. (1) The adjustment to the operating portion of the rate to reflect the costs of retaining and recruiting nursing services shall be made as follows:

(i) A percentage figure shall be determined as follows:

(a) An average annual statewide increase in registered nurses and licensed practical nurses salaries between the calendar year ending 1987 and calendar year ending 1988 shall be determined based on the available ratified nursing contracts for general hospital services and an average annual regional increase in registered nurses and licensed practical nurses salaries between the calendar year ending 1987 and calendar year ending 1988 shall be determined based upon available information for residential health care facilities.

(b) The average annual regional and statewide increase in salaries shall be multiplied by the total number of nursing staff in the region and the total number of nursing staff statewide respectively to arrive at the total regional and statewide adjustment to be made to facilities. The total regional adjustments shall be determined using the regions contained in Appendix 13-A herein.

(c) The adjusted base shall be determined by multiplying the facility specific mean price per day determined pursuant to subparagraph (i) of paragraph (4) of subdivision (c) of this section by total patient days for each facility and the result shall be summed on a regional and statewide basis.

(d) The total adjustment to be made for all facilities determined pursuant to clause (b) of this subparagraph shall be divided by the adjusted base determined pursuant to clause (c) of this subparagraph on a regional and statewide basis to determine the regional percentage increase and the statewide percentage increase.

MAY 16 1986

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(e) The facility specific percentage shall be determined by summing 40 percent of the statewide percentage and 60 percent of the corresponding regional percentage determined pursuant to clause (d) of this subparagraph.

(ii) The adjustment to the rate for a facility shall be determined by applying the facility specific percentage figure calculated in subparagraph (i) of this paragraph to a facility's adjusted base and added to the operating portion of the rate.

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New York  
47(t)

Attachment 4.19-D  
(04/09)

The Commissioner of Health shall adjust medical assistance rates of payment for services provided on or after April 1, 2002, established pursuant to this section for non-public residential health care facilities for purposes of recruitment and retention of health care workers in the following aggregate amounts for the following periods:

For non-public residential health care facilities, \$53.5 million on an annualized basis for the period April 1, 2002 through December 31, 2002; \$83.3 million on an annualized basis for the period January 1, 2003 through December 31, 2003; \$115.8 million on an annualized basis for the period January 1, 2004 through December 31, 2006; \$57.9 million for the period January 1, 2007 through June 30, 2007; \$57.9 million for the period July 1, 2007 through March 31, 2008; and \$64.8 million for the period May 8, 2008 through March 31, 2009[, and \$26.2 million for the period April 1, 2009 through March 31, 2010].

For periods through June 30, 2007, for non-public residential health care facilities, such increases shall be allocated proportionally based on each non-public residential health care facility's reported total gross salary and fringe benefit costs on exhibit H of the 1999 RHCF-4 cost report or exhibit 11 of the 1999 institutional cost report as submitted on or before November 1, 2001, where applicable, to the total of such reported costs for all non-public residential health care facilities.

For periods on and after July 1, 2007, for non-public residential health care facilities, 50% of such increases shall be allocated proportionally based on each such facility's salary and fringe benefit costs as reported on Exhibit H in the 1999 cost report submitted prior to November 1, 2001, to the total of such costs for all non-public facilities. The remaining 50% of such increases shall be allocated proportionally based on each non-public facility's Medicaid revenue as reported in the applicable 2005 cost report submitted prior to November 1, 2006, to the total of such Medicaid revenue for all non-public facilities.

Non-public residential health care facilities in operation as of April 1, 2002, which have not submitted 1999 RHCF-4 cost reports or 1999 institutional cost reports, but which have submitted such reports for cost years subsequent to 1999, shall have such increases allocated based on total gross salary and fringe benefit costs on exhibit H of the earliest subsequently submitted institutional cost report or exhibit 11 of the earliest subsequently submitted institutional cost report, as trended downward to 1999 using authorized trend factors. These trend factors shall be developed in accordance with Page 51(a) of this Attachment and will be consistent with those used in the calculation of the facility's reimbursement rates.

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JAN 25 2011

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APR - 1 2009

**New York  
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**Attachment 4.19-D  
(07/07)**

Non-public residential health care facilities in operation as of April 1, 2002, which have not submitted 1999 or subsequent RHCF-4 cost reports or institutional cost reports, shall have such increases allocated based on imputed total gross salary and fringe benefit costs reflecting the average of such 1999 actual reported costs in the region in which each facility is located. Facilities receiving allocations pursuant to this paragraph which subsequently submit RHCF-4 cost reports or institutional cost reports shall, for the purpose of setting medical assistance rates of payment, have such allocations adjusted to reflect costs which were incurred in connection with such allocations and which are contained in such cost reports.

These amounts shall be included as a reimbursable cost add-on to medical assistance fee-for-service rates of payment established pursuant to this section, based on Medicaid utilization data in each facility's annual cost report submitted two years prior to the rate year or projected Medicaid utilization data for those facilities that have not submitted an annual cost report for the period two years prior to the rate year. Such amounts shall not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

DEC 19 2007

TN #07-36

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Effective Date JUL 1 2007

New York  
47(t)(2)

Attachment 4.19-D  
(07/07)

**Criminal Background Checks**

Effective April 1, 2005, residential health care facility providers must obtain a criminal history record check from the United States Attorney General for any prospective unlicensed direct care employee. This includes obtaining, as part of an application for employment, all information from a prospective employee necessary for initiating the criminal history record check, including, but not limited to, a fingerprint card of the prospective employee. The federal fee and the costs associated with obtaining the fingerprint card shall be separately identified on any report of costs submitted to the Department of Health and shall be deemed an allowable cost for Medicaid rates of payment. Reimbursement for the period April 1, 2005 through March 31, 2006 and for the period April 1, 2006 through August 31, 2006, shall be made retrospectively based upon cost reports submitted for the 2005 and 2006 rate years, respectively. For new providers or existing providers for which cost report data are unavailable, payment will be based on budgeted costs and subsequently adjusted to reflect actual costs. Reimbursement for all types of providers shall total no more than \$5,000,000 for the April 1, 2005 through March 31, 2006 period and no more than \$13,400,000 for the April 1, 2006 through August 31, 2006 period. Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current rates of payment and will be determined by the percent of Medicaid utilization to total utilization for each provider. If the total cost for these criminal background checks for all types of providers exceeds the amounts set forth for the specified period, provider specific reimbursement will be reduced proportionally.

Effective September 1, 2006, residential health care facilities shall request criminal history background checks from the Department of Health for unlicensed prospective employees who will provide direct care or supervision to patients, residents, or clients of such providers. The criminal history information consists of both a state and a national criminal history check.

Residential health care facilities may claim as reimbursable costs under the medical assistance program, costs reflecting the fee established pursuant to law by the NYS Division of Criminal Justice Services for processing a state criminal history information check, the fee imposed by the Federal Bureau of Investigation for a national criminal history check, and certain other costs associated with obtaining the fingerprints. These costs shall be separately identified on any report of costs submitted to the Department of Health.

Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current Medicaid rate of payment based on the costs reported for the period two years prior to the rate period and will be determined by the percent of Medicaid utilization to total utilization for each provider.

DEC 19 2007

TN #07-36

Approval Date

Supersedes TN #06-69

Effective Date

JUL 1 2007

(s) Adjustment of rates pursuant to methodology changes effective October 1, 1990 and April 1, 1991.

(1) Rate changes resulting from the [Amendments] amendments to sections 86-2.1(a), 86-2.9(c), 86-2.10(a)(3), (c)(1)-(5), (d)(1) & (2) and (p)(2)(.) and (3) [& (4)], and 86-2.30(c)(3) of this Title effective October 1, 1990, and amendments to sections 86-2.10(a)(3), (c)(1), (3) and (5), (d)(1), (2) and (4)-(7), (p)(1)-(3), and (t)(1) and (2) of this Title effective April 1, 1991 shall be [reflected in 1990 and 1991 rates pursuant to the following schedule] as follows:

(i) For rates with effective dates commencing between October 1, 1990 to [March 31, 1991] and June 30, 1992, [actual rate change shall not exceed 0 percent] the rate shall be computed using the rate methodology in effect on September 30, 1990, adjusted by the most recent PRI submissions applicable to the effective period of the rate, and the adjustment to the regional direct and indirect input price adjustment factors pursuant to subparagraph (iv) of paragraph (1) of subdivision (m) of this section.

(ii) [For rates with effective dates commencing between April 1, 1991 to June 30, 1991, actual rate change shall not exceed 2 percent.

(iii) For rates with effective dates commencing between July 1, 1991 to September 30, 1991, actual rate changes shall not exceed 4 percent.

(iv) (ii) For rates with effective dates commencing on or after [October 1, 1991] July 1, 1992, the full impact of the [methodology] rate changes [effective on October 1, 1990] cited in paragraph (1) of this subdivision shall be reflected in rates.

(iii) Those facilities with an initial budgeted rate or revised cost-based rate which reflects a change in base year and which is effective after April 1, 1991, shall receive the full impact of the methodology changes cited in paragraph (1) of this subdivision on the effective date of such rate.

(2) For facilities having multiple rates based on levels of care prior to October 1, 1990, such rates shall be combined for the establishment of rates effective October 1, 1990 to [March 31, 1991] June 30, 1992 based on a weighted average of reported Medicaid days for each previous level of care for the latest available cost reporting period. Where the Department is authorized expressly by statute to adjust rates retrospectively, for both positive and negative rate adjustments, such combined rate shall be adjusted by a reconciliation of reported Medicaid days to actual billed Medicaid days for the effective period, provided that such adjustment results in a combined direct and indirect component rate change of more than 5%. Such combined rate shall reflect the amendments referenced in paragraph (1) of this subdivision pursuant to the schedule set forth therein.

(3) Notwithstanding the provisions of paragraph (1) of this subdivision, residential health care facilities which have been identified by the Department as requiring registered nurse staffing increases to provide seven days a week, eight hours per day of day shift registered nurse coverage shall receive rate changes effective October 1, 1990 at a level sufficient to compensate

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JUL 11 1994

Supersedes Title 90-10 Effective Date APR 1 - 1991

facilities for additional expenses of expanding registered nurse coverage based upon a survey of costs to be incurred by affected facilities.

(4) Nothing within this subdivision shall preclude the Department from fully implementing rate adjustments on or after October 1, 1990, which are unrelated to methodology changes referenced in paragraph (1) of this subdivision.

(t) Base Year Adjustment for Facilities Who Have Bed Conversions.\* A facility shall be eligible for an adjustment to its base year costs if its proportion of beds identified as skilled nursing facility beds and health related facility beds as of the first day of its base period differs from the proportion of beds identified as skilled nursing facility beds and health related facility beds as of September 30, 1990. The adjustment shall be separately determined for the direct, indirect, and non-comparable components of a facility's allowable base period costs, and each adjustment shall be added to a facility's allowable direct, indirect and non-comparable costs, respectively, prior to group comparisons. The amount of the adjustment shall be determined as follows:

(1) Base period direct, indirect, and non-comparable costs per bed adjusted for occupancy level shall be separately calculated for both skilled nursing and health related facility beds. The changes in skilled nursing and health related facility beds for the period defined in the above paragraph shall be multiplied by the applicable cost per bed and added together to arrive at each adjustment amount.

(2) An adjustment to allowable days shall also be made for a facility whose total number of beds has changed for the period described in this subdivision to reflect the skilled nursing facility and health related facility occupancy levels used in the calculation of rates effective September 30, 1990. Base period days shall be adjusted by the proportion of total new beds as of September 30, 1990 to total base year beds prior to the determination of the

\* for rates effective July 1, 1992

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facility-specific price per day for the facility's direct, indirect, and non-comparable cost components.

(u) Adjustment for Additional Federal Requirements. A facility whose rate is based on allowable or budgeted costs for a period prior to April 1, 1991 shall be considered eligible to receive a per diem adjustment to its rate as follows:

(1) A per diem adjustment shall be incorporated into each facility's rate to take into account the additional reasonable costs incurred by facilities in complying with the requirements of subsection (b), (other than paragraph 3(F) thereof), (c), and (d) of section 1919 of the federal Social Security Act effective October 1, 1990 as added by the federal Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). Additional reasonable costs resulting from such federal requirements shall include additional reasonable costs in the following areas: the completion of resident assessments, the development and review of comprehensive care plans for residents, staff training for the new resident assessment tool, quality assurance committee costs, nurse aide registry costs, psychotropic drug reviews, and surety bond requirements.

(i) The per diem adjustment shall be forty-five cents computed on a statewide basis and shall be regionally adjusted to reflect differences in registered nurse salary levels for calendar year 1987. Any costs over the per diem adjustment shall be deemed attributable to factors other than compliance with the federal requirements referenced in this subdivision.

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47(w)(1)

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(ii) For purposes of inclusion in facility rates for 1991, the annual incremental per diem add-on shall be effective for the nine month period beginning April 1, 1991 and further adjusted so that the nine months of incremental cost are reflected in a per diem adjustment for July 1, 1991 through December 31, 1991 rates.

(2) For rates years beginning on or after January 1, 1992, the annual incremental per diem add-on calculated pursuant to subparagraph (i) of paragraph (1) shall be trended forward by the applicable facility trend factor.<sup>1</sup>

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<sup>1</sup> Trend factors are computed in accordance with Section 86-2.12 of this Plan.

### Description of the Specific Methodology Used in Determining the Adjustment

In order to determine the impact of the federal law on New York facilities, a cost estimate was made for each added code requirement. The total average additional cost was determined to be 45 cents per patient day.

#### Resident Assessments

Since New York State facilities were required prior to the new federal code to conduct accurate and comprehensive assessments, the additional cost pertains to completion of the MDS+<sup>2</sup> document and RN coordination and certification of completeness. No discipline other than RN is required, although facilities may choose to assign portions of the MDS+ to various disciplines as appropriate. Physician responsibilities remain the same as prior to the new code.

Comprehensive assessments include those performed on initial admission, annually, and upon significant change in resident status. It is estimated that there will be 1.48 comprehensive assessments per bed in 1991. This was based on an estimated significant change rate of 50% of the beds per year, and a 45% turnover rate per year. One twelfth of the annual assessments will be completed each month. Similarly, one twelfth of the assessments necessitated by the 45% turnover rate and the 50% significant change rate will also be completed each month. Half of the time, either of the latter two assessments will occur before the scheduled annual assessment of the resident in that bed, and the scheduled annual assessment will therefore not be necessary for that resident. The number of scheduled annual assessments not necessary under this methodology equals half of the new admit assessments and residents with a significant change, or  $(.45) + (.5) = .95$ . The total number of assessments per bed would be  $.48 + .95 = 1.43$ .

.48 = 1.48.

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<sup>2</sup>MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)

Based on a time study of the MDS<sup>3</sup>, it was estimated that each comprehensive assessment would require one hour and forty five minutes, or forty five minutes longer than current practice. An average RN hourly salary rate of \$24.00 as reported by industry representatives was used to make this calculation. The total cost was estimated as follows:

(# assessments/bed) (# beds) (incremental time/assessment)

(1.48) (105,000) (.75) (\$24) = \$2,797,200 for comprehensive assessments

Quarterly resident assessment reviews are estimated to be 2.2 per bed per year, at 30 minutes per assessment, with the remaining assumptions the same as for comprehensive assessments.

(2.2) (105,000) (.5) (\$24) = \$2,772,000 for quarterly assessments

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<sup>3</sup>MDS (Minimum Data Set)

### Comprehensive Care Plan

The incremental cost of comprehensive care plans for all residents was estimated by determining the added time of each participating discipline and multiplying by the average salary rate for that discipline. Physician participation in the care planning process has been a standard of practice in this State, and no additional time should be necessary under the new code. Based on an analysis of 1990 Patient Review Instrument (PRI) data, physical therapy (provided by a licensed physical therapist) was received by 21% of residents, and 9% received occupational therapy. Based on the new code requirements, it is estimated that twice this number, or 42% PT and 18% OT, will require additional care planning participation by these therapists. For those residents requiring PT/OT services, an additional half hour of PT/OT time will now be required. At an industry estimated hourly rate of \$31.50 for physical therapists and \$30.00 for occupational therapists, the added cost would be \$15.74 for PT and \$15.00 for OT for care plans for patients receiving therapy. The nursing home industry estimated that RN, social worker, dietician, and activities worker care planning time for 100 of care plans would each increase by .5 hour. The hourly rates provided by the industry for RNs were \$24.00, for social workers \$15.40, for dietician \$21.00, for activities workers \$10.00. Based on 1.48 care plans per bed (using the number of comprehensive assessments per year), the calculation is as follows:

(# plans/bed) (# beds for all residents) (incremental time for each discipline x hourly rate x percent of care plans involving discipline) = statewide cost

$$(1.48) (105,000) ((.5 \times \$24 \times 100\%) + (.5 \times \$15.40 \times 100\%) + (.5 \times \$21.00 \times 100\%) + (.5 \times \$10.00 \times 100\%) + (.5 \times \$31.50 \times 42\%) + (.5 \times \$30.00 \times 18\%)) = \$6,917,631$$

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Quarterly Plan Reviews

Only an RN is involved in the incremental activities required by OBRA. The industry's estimate of 2.2 quarterly care plans per year at an incremental cost of \$6.00 per review was used:

(# care plans/bed) (# beds) (incremental cost/plan) = statewide cost

(2.2) (105,000) (\$6.00) = \$1,386,000

Training on MDS Assessment

An estimate of 70,020 was used, based on the industry's estimate which was found acceptable.

Cost of training for up to 80 beds	\$229,950
80 bed increments	<u>\$140,070</u>
	\$370,020

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### Quality Assurance

The meeting and preparation time for quarterly Quality Assurance meetings, including committee members of a physician, director of nursing, administrator or designee and three other staff was estimated by the industry. This was offset by the elimination of separate pharmacy reviews and infection control meetings, as well as the existing utilization review assessment and U/R committee meetings. Three added staff involved in meetings are assumed to be the physical therapist, social services director and a representative from medical records. The net added expense estimated by the industry was \$600,264.

### Recertification of Nurse Aides

The number of aides who must be recertified by 1/92 is 17,381. The cost of recertification is \$25.00 per aide. The total recertification cost is \$434,525.

### Psychotropic Drug Reviews

The code requires that all residents receiving psychotropic medications be reviewed with the intent of minimizing the usage of such drugs. These reviews are assumed to involve the physician and take about .5 hours per resident. It is estimated that 20% of residents will need such review at physician cost of \$150 per hour.

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$105,000 \times 20\% \times .5 \times \$150 = \$1,575,000$

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Surety Bonds

The industry has estimated that \$189,000 of added cost will be incurred for this requirement and was found acceptable.

SUMMARY OF INCREMENTAL CODE COSTS TO BE REIMBURSED

Total incremental federal code cost to be recognized in facility 1991 rates is \$17,041,640.

Comprehensive Resident Assessment	\$ 2,797,200
Quarterly Resident Assessment	2,772,000
Comprehensive Care Plan	6,917,631
Quarterly Care Plan Review	1,386,000
Training of MDS+ <sup>5</sup> Assessment	370,020
Quality Assurance	600,264
Nurse Aide	434,525
Psychotropic Drug Review	1,575,000
Surety Bonds	<u>189,000</u>
Total Incremental Cost	\$17,041,640

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<sup>5</sup>MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)

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Costs are to be reflected in facility rates beginning July 1 1991, so that the nine months of incremental cost from April 1, 1991 to December 1991 will be reflected in the six month rate period July to December 1991. Total incremental costs were converted to a per diem add-on to be included in a facility's rate by dividing total incremental costs by available beds, and adjusting to days by dividing by 365. The calculation is as follows:

$$\$17,041,640 / 105,000 / 365 = .45 \text{ add-on}$$

This statewide add-on will be adjusted for each facility to reflect regional differences in RN salary levels for calendar year 1987. Such regional adjustments are currently used in the determination of the direct and indirect components of facility rates. For 1992 and forward, the incremental cost add-on will be increased by the appropriate trend factor.<sup>6</sup>

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<sup>6</sup> Trend factors are computed in accordance with Section 86-2.12 of this Plan.

**Description of Methodologies for the Physical, Mental, and Psychosocial Well Being Requirement**

The State of New York reimbursement rates match payment with intensity of care, thus providing facilities with adequate reimbursement for patients requiring more intensive supportive, medical or rehabilitative care. The RUG II patient classification system classifies each patient into one of sixteen patient categories which are each different in terms of clinical characteristics and are statistically different in terms of costs of care.

The system uses a hierarchy of patient types and secondary subgroup format based on Activities of Daily Living (ADL) function levels. The five hierarchical groups, from the highest to lowest resource consumption, are as follows:

1. Special Care
2. Rehabilitation
3. Clinically Complex
4. Severe Behavioral Problems
5. Reduced Physical Functions

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Each of the above clinical groups is further divided by the ADL index score into subgroups. The ADL index is comprised of three ADL variables, eating, toileting, and transfer, which were determined to be the key predictors of resource consumption within each clinical group. For each of the sixteen patient classification categories, a relative resource "weight" representing the resource consumption of patients in that category relative to the average patient, is used to adjust the direct component of the payment rate.

The RUGS system thus allows a more precise and equitable means of directing available fiscal resources to nursing homes that care for residents with the heaviest care needs. By recognizing the resources required to provide more intensive rehabilitative and support services, the reimbursement methodology encourages nursing homes to establish restorative care programs. This can result in more active intervention for eligible patients, and earlier improvement and discharge.

October 1, 1992

For rates effective January 1, 1992 and thereafter, the per diem add-on described herein will be increased by a trend factor as defined in Section 86-2.12 of this Plan.

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Description of the specific methodology for determining the adjustment  
Bloodborne Pathogens

**Hepatitis B Vaccination:**

Beginning January 1, 1993 and thereafter, provider rates contain a facility specific adjustment to reimburse the cost of the Hepatitis B vaccine administered to employees. Provider-specific adjustments are based upon each facility's actual costs recognized up to a maximum cost for the vaccine. The facility specific adjustment will be determined using costs reported by the providers two years prior to the start of the rate year. The maximum cost for the vaccine that is recognized when setting the facility specific adjustment is \$128.50 for a three vial series per employee.

**Gloves:**

For rates effective on April 1, 1994 for the 1994 calendar year and each calendar year thereafter, an \$.18 per diem adjustment will be included in provider's rates for the incremental cost of gloves.

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Reserved.

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(v) Extended care of residents with traumatic brain injury.

(1) (i) Except as provided in subparagraph (ii) of this paragraph, effective April 1, 1993, a per diem amount of \$25, adjusted by the RDIPAF determined pursuant to paragraph (5) of subdivision (c) of this section, and increased in rate years thereafter, by the projection factors determined pursuant to section 86-2.12 shall be added to a facility's payment rate determined pursuant to this Subpart for each resident with traumatic brain injury identified as requiring extended care and receiving services pursuant to section of this Title.

(ii) Effective with rates revised based upon patient review instrument (PRI) assessment data for an assessment period set forth in Section 86-2.11(b) of this Subpart beginning on or after November 1, 1994, a TBI patient per diem amount shall be added to a facility's average Medicaid payment rate determined pursuant to this Subpart only for Medicaid residents with traumatic brain injury identified as requiring extended care which shall mean a person who is at least three months post-injury and who has been diagnosed as having a cognitive and/or physical condition that has resulted from traumatically acquired, non-degenerative, structural brain damage, or anoxia, and who in addition has participated in an intensive inpatient rehabilitation program for persons with TBI in a hospital or nursing home and has been assessed by a neurologist or physiatrist who determined that the individual would no longer benefit from an intensive rehabilitation program. The TBI patient per diem amount shall be determined as follows: The total number of Medicaid traumatic brain injury (TBI) extended care residents shall be multiplied by \$25 per patient day times 365 days to determine the annual TBI amount. The annual TBI amount shall then be adjusted by the facility RDIPAF, determined pursuant to subdivision (c)(5) of this section, to establish the allowable TBI dollars. The allowable TBI dollars shall be divided by the facility total annual Medicaid days to determine the facility TBI patient per diem amount. The TBI patient per diem amount shall be increased annually by the projection factor determined pursuant to section 86-2.12 of this Subpart. For purposes of this subdivision, a Medicaid resident is defined as a resident whose primary payor description is coded as Medicaid on the PRI assessment data.

(2) Residents reimbursed pursuant to this subdivision shall not be reimbursed pursuant to subdivision (n) and (o) of this section.

TN 95-04

Date JUN 4 - 1999

Supersedes TN 94-44

Date JAN - 1 1995

New York  
47(x)(2)

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Rates of payment for non-state operated public residential health care facilities shall be increased in an aggregate amount of \$100 million for payments for services provided during the period July 1, 1995 through March 31, 1996. To be eligible, the facility must be operating at the time the pool is distributed. Payment to each eligible facility shall be in proportion to the facility's 1994 Medicaid days relative to the sum of 1994 Medicaid days for all eligible facilities.

TN 95-24-A Approval Date MAR 27 1997  
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New York  
47(x)(2)(a)

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For the period August 1, 1996 through March 31, 1997, proportionate share payments in the aggregate amount of \$257 million shall be made under the medical assistance program to non-state operated public residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. Payments shall be made as a lump sum payment to each eligible residential health care facility.

The amount allocated to each eligible public residential health care facility shall be calculated as the result of \$257 million multiplied by the ratio of 1994 facility Medicaid patient days divided by the total of all Medicaid patient days for all eligible public residential health care facilities. The payments are made contingent upon receipt of all approvals required by federal law or regulation.

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**New York  
47(x)(2)(b)**

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(04/07)**

For the period April 1, 1997 through March 31, 1999, proportionate share payments in an annual aggregate amount of \$631.1 million shall be made under the medical assistance program to non-state public operated residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For the period April 1, 1999 through March 31, 2000, proportionate share payments in an annual aggregate amount of \$982 million shall be made under the medical assistance program to non-state operated public residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For annual state fiscal year periods commencing April 1, 2000 and ending March 31, 2005, and April 1, 2005, through March 31, [2007] 2009, proportionate share payments in an annual aggregate amount of up to \$991.5 million and \$150.0 million, respectively, shall be made under the medical assistance program to non-state operated public residential health care facilities, including public residential health care facilities located in the counties of Erie, Nassau and Westchester, but excluding public residential health care facilities operated by a town or city within a county.

The amount allocated to each eligible public residential health care facility for the period April 1, 1997 through March 31, 1998 shall be calculated as the result of \$631.1 million multiplied by the ratio of their 1995 Medicaid days relative to the sum of 1995 Medicaid days for all eligible public residential health care facilities. The amount allocated to each eligible public residential health care facility for the period April 1, 1998 through March 31, 1999 shall be calculated as the result of \$631.1 million multiplied by the ratio of their 1996 Medicaid days relative to the sum of 1996 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for the period April 1, 1999 through March 31, 2000 shall be calculated as the result of \$982 million multiplied by the ratio of their 1997 Medicaid days relative to the sum of 1997 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for annual state fiscal year periods commencing April 1, 2000 and ending March 31, 2005, and for annual state fiscal year periods commencing April 1, 2005 through March 31, [2007] 2009, shall be calculated as the result of up to \$991.5 million and \$150.0 million, respectively, multiplied by the ratio of their Medicaid days relative to the sum of Medicaid days for all eligible public residential health care facilities for the calendar year period two years prior. The payments are made contingent upon receipt of all approvals required by federal law or regulation.

Payments shall be made as a lump sum payment to each eligible residential health care facility.

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Supersedes TN     #06-24     Effective Date     APR - 1 2007

New York  
47(x)(3)

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prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facilities cost report submitted pursuant to this Subpart is less than the staffing pattern ~~required by~~ identified in ~~section 415.39 of this title~~ Appendix 3 of this State Plan.

(2) In determining the indirect component of a facility's rate pursuant to paragraphs (d)(4)-(6) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, a facility's indirect costs shall be compared to the peer group established pursuant to clause (d)(2)(iii)(a) of this section.

(3) The noncomparable component of such facilities' rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart including approved actual cost in such cost report for personnel that would be reported in the functional cost centers identified in subdivision (f) of this section.

~~{(4) The provision of this subdivision will expire on December 31, 1994.}~~

TN 95-04

JUN 4 - 1999

Supersedes TN New Date JAN - 1 1995

New York  
47(x)(4)

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(04/06)

- (x) Residential health care facility rates of payment for services provided on or after July 1, 1995 through March 31, 1996 shall be reduced by the Commissioner to reflect the elimination of operational requirements previously mandated by law or regulation or the Commissioner or other governmental agency, by a factor determined as follows:
- (i) an aggregate reduction shall be calculated for each residential health care facility as the result of (a) up to fifty-six million dollars on an annualized basis for 1995, trended to the rate year by the trend factor for projection of reimbursable costs to the rate year, multiplied by (b) the ratio of patient days for patients eligible for payments made by government agencies provided in a base year two years prior to the rate years by a residential health care facility, divided by the total of such patient days summed for all residential health care facilities; and
- 
- (ii) the result for each residential health care facility shall be divided by such patient days for patients eligible for payment made by governmental agencies provided in the residential health care facility, for a per diem reduction in rates of payment for such residential health care facility for patients eligible for payments made by governmental agencies.
- (iii) Effective April 1, 1996 through March 31, 1999 and on or after July 1, 1999 through [March] December 31, 2006 residential health care facility rates of payment shall be reduced by an annual aggregate amount of fifty-six million dollars to encourage improved productivity and efficiency. Actual reduction in rates within such aggregate amounts will be allocated among facilities based upon each facility's ratio of Medicaid utilization to total statewide Medicaid utilization for all residential health care facilities.

TN #06-21

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New York  
47(x) (5)

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(w) Specialized programs for residents requiring behavioral interventions. Facilities which have been approved to operate discrete units specifically designed for the purpose of providing specialized programs for residents requiring behavioral interventions as established pursuant to section 415.39 of this Title shall have separate and distinct payment rates calculated pursuant to this section except as follows:

(1) In determining the facility specific direct adjusted payment price per day pursuant to paragraph (c) (4) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, the case mix index used to establish the statewide ceiling price per day for each patient classification group pursuant to subparagraph (c) (3) (iii) of this section for such residents shall be increased by an increment of 1.40. In determining the case mix adjustment pursuant to paragraph (c) (6) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.40.

(i) Specific interventions that the Department has approved which qualify for payment are a combination of medical and behavioral interventions such as counseling, recreation and exercise carried out in a therapeutic environment and provided on-site. Nursing resident criteria to be used in determining eligibility for payment include assessment of whether the resident is a danger to self or others and displays violent or aggressive behaviors which are typically exhibited as physical or verbal aggression such as clear threats of violence. The behavior may be unpredictable, recurrent for no apparent reason, and typically exhibited as assaultive, combative, disruptive or socially inappropriate behavior such as sexual molestation or fire setting.

(ii) The increment established in paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or

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prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility's cost report submitted pursuant to this Subpart is less than the staffing pattern required below.

A current period audit of current period expenses will result in an incremental adjustment implemented on a prospective basis. An audit of prior period expenses will result in a retrospective adjustment in a lump sum payment. The staffing pattern required by the department is as follows:

- (a) The unit shall be managed by a program coordinator;
- (b) A physician shall be responsible for medical director and oversight of the program;
- (c) A qualified specialist in psychiatry, a psychologist and a social worker shall be available on staff on a consulting basis;
- (d) Other than the program coordinator, there shall be at least one registered professional nurse on each shift.

(2) In determining the indirect component of a facility's rate pursuant to paragraphs (d)(4)-(6) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, a facility's indirect costs shall be compared to the peer group established pursuant to clause (d)(2)(iii)(a) of this section.

(3) The noncomparable component of such facilities' rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart including approved actual cost in such cost report for personnel required by section 415.39 of this Title that would be reported in the functional cost centers identified in subdivision (f) of this section.

(4) The provision of this subdivision will expire on December 31, 1994.

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**Medicare Utilization.** (1)(a) Prior to February 1, 1996 the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to Medicare beneficiaries, divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period commencing July 1, 1995 to the last date for which such data is available and reasonably accurate. This value shall be called the 1995 statewide target percentage.

(b) Prior to February 1, 1997, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period commencing January 1, 1996 through November 30, 1996 based on such data for such period as is available and reasonably accurate. This value shall be called the 1996 statewide target percentage.

(c) Prior to February 1, 1998, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal

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social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1997 through November 30, 1997 based on such data as is available and reasonably accurate. This value shall be called the 1997 statewide target percentage.

(d) Prior to February 1, 1999, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of Title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1998 through November 30, 1998 based on such data as is available and reasonably accurate for such period. This value shall be called the 1998 statewide target percentage.

(e) Prior to February 1, 2000 the commissioner of health shall calculate the result of the statewide total of residential health care

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facility days of care provided to beneficiaries of Title XVIII of the [federal] [s]Social [s]Security [a]Act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to [t]Title 11 of [a]Article 5 of the [s]Social [s]Services [l]Law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1999 through November 30, 1999, based on such data for such period. This value shall be called the 1999 statewide target percentage.

- (f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007, February 1, 2008, [and] February 1, 2009, February 1, 2010, and February 1, 2011, the Commissioner of Health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of [t]Title XVIII of the [federal] [s]Social [s]Security [a]Act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to [t]Title 11 of [a]Article 5 of the [s]Social [s]Services [l]Law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, [and] 2009, 2010, and 2011, statewide target percentage respectively.
- (2) Prior to February 1, 1996, the Commissioner of Health shall calculate the results of the statewide total of health care facility

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days of care provided to Medicare beneficiaries, divided by the sum of days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period April 1, 1994 through March 31, 1995. This value shall be called the statewide base percentage.

(3) (a) If the 1995 statewide target percentage is not at least one percentage point higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the 1995 statewide target percentage is not at least one percentage point higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1995 statewide reduction percentage. If the statewide target percentage is at least one percentage point higher than the statewide base percentage, the statewide reduction percentage shall be zero.

(b) If the 1996 statewide target percentage is not at least two percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the 1996 statewide target percentage is not at least two percentage points higher than the statewide base percentage. The percentage calculated pursuant to this subdivision shall be called the 1996 statewide reduction percentage. If the

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1996 statewide target percentage is at least two percentage points higher than the statewide base percentage, the 1996 statewide reduction percentage shall be zero.

- (c) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, [and] 2009, 2010, and 2011, statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the Commissioner of Health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, [and] 2009, 2010, and 2011, statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, [and] 2009, 2010, and 2011, statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.
- (d) If the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage, the Commissioner of Health shall determine the percentage by which the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1999 statewide reduction percentage. If the 1999 statewide target percentage is at least two and one-quarter percentage points higher than the statewide base percentage, the 1999 statewide reduction percentage shall be zero.

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- (4) (a) The 1995 statewide reduction percentage shall be multiplied by [thirty-four] \$34 million [dollars] to determine the 1995 statewide aggregate reduction amount. If the 1995 statewide reduction percentage shall be zero, there shall be no reduction amount.
- (b) The 1996 statewide reduction percentage shall be multiplied by [sixty-eight] \$68 million [dollars] to determine the 1996 statewide aggregate reduction amount. If the 1996 statewide reduction percentage shall be zero, there shall be no reduction amount.
- (c) The 1997 statewide reduction percentage shall be multiplied by [one hundred two] \$102 million [dollars] to determine the 1997 statewide aggregate reduction amount. If the 1997 statewide reduction percentage shall be zero, there shall be no 1997 reduction amount.
- (d) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, [and] 2009, 2010 and 2011, statewide reduction percentage shall be multiplied by [one hundred two] \$102 million [dollars] respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, [and] 2009, 2010, and 2011, statewide aggregate reduction amount. If the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, [and] 2009, 2010, and 2011, statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, [and] 2009, 2010, and 2011, statewide reduction amount.

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- (e) The 1999 statewide reduction percentage shall be multiplied by [seventy-six million five hundred thousand dollars] \$76.5 million to determine the 1999 statewide aggregate reduction amount. If the 1999 statewide reduction percentage shall be zero, there shall be no 1999 reduction amount.
- (5) (a) The 1995 statewide aggregate reduction amount shall be allocated by the Commissioner of Health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to [t]Title 11 of [a]Article 5 of the [s]Social [s]Services [l]Law on the basis of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage. This amount shall be called the 1995 facility specific reduction amount.
- (b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, [and] 2009, 2010, and 2011, statewide aggregate reduction amounts shall for each year be allocated by the Commissioner of Health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to [t]Title 11 of [a]Article 5 of the [s]Social [s]Services [l]Law on the basis of the extent of each facility's failure to achieve a two percentage point[s] increase in the 1996 target percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, [and] 2009, 2010, and 2011, target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage point[s] increase in the 1996, a three percentage point increase in the 1997, and a

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three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage and a three percentage point increase in the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, [and] 2009, 2010, and 2011, target percentage compared to the base percentage. These amounts shall be called the 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, [and] 2009, 2010, and 2011, facility specific reduction amounts respectively.

(6) The facility specific reduction amounts shall be due to

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the state from each residential health care facility and may be recouped by the state in a lump sum amount from payments due to the residential health care facility pursuant to title 11 of article 5 of the social services law.

(7) Residential health care facilities shall submit such utilization data and information as the commissioner of health may require for purposes of this section. The commissioner of health may use utilization data available from third party payers.

(8)(a) On or about June 1, 1996, the commissioner of health shall calculate for the period July 1, 1995 through March 31, 1996 statewide target percentage, statewide aggregate reduction amount, and a facility specific reduction amount in accordance with the methodology provided in paragraphs 1(a), 3(a), 4(a) and 5(a) of this provision. The facility specific reduction amount calculated in accordance with this paragraph shall be compared to the 1995 facility specific reduction amount calculated in accordance with paragraph 5(a) of this provision. Any amount in excess of the amount determined in accordance with paragraph 5(a) of this provision shall be due to the state from each residential health care facility and may be recouped in the same manner as specified in paragraph 6 of this provision. If

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the amount is less than the amount determined in accordance with paragraph 5(a) of this provision, the difference shall be refunded to the residential health care facility by the state no later than July 15 1996. Residential health care facilities shall submit utilization data for the period July 1, 1995 through March 31, 1996 to the commissioner of health by April 15, 1996.

(b) On or about June 1, 1997, the commissioner of health shall calculate for the period January 1, 1996 through November 30, 1996 a statewide target percentage, a statewide reduction percentage, a statewide aggregate reduction amount, and a facility specific reduction amount in accordance with the methodology provided in paragraph 1(b), 3(b), 4(b) and 5(b) of this provision. The facility specific reduction amount calculated in accordance with this paragraph shall be compared to the 1996 facility specific reduction amount calculated in accordance with paragraph 5 (b) of this provision. Any amount in excess of the amount determined in accordance with paragraph 5(b) of this provision shall be due to the state from each residential health care facility and may be recouped in the same manner as specified in paragraph 6 of this provision. If the amount is less than the amount determined in accordance with paragraph 5(b) of this provision, the difference shall be refunded to the residential health care facility by the state no later than

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July 15, 1997. Residential health care facilities shall submit utilization data for the period January 1, 1996 through November 30, 1996 to the commissioner of health by April 15, 1997.

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**Rate Adjustment for Financially Disadvantaged RHCFS**

- (a) The Commissioner of Health shall, within amounts appropriated for the purposes of this section, adjust medical assistance rates of payment for services provided on and after October 1, 2004 through December 31, 2004 and annually thereafter for services provided on and after January 1, 2005, to include a rate adjustment to assist qualifying residential health care facilities (RHCFS) pursuant to this section.
- (b) Eligibility for such rate adjustments shall be determined on the basis of each RHCFS's operating margin over the most recent three-year period for which financial data are available from the RHCFS-4 cost report or the institutional cost report. For purposes of the adjustments made for the period October 1, 2004 through December 31, 2004, financial information for the calendar years 2000 through 2002 shall be utilized. For each subsequent rate year, the financial data for the three-year period ending two years prior to the applicable rate year shall be utilized for this purpose.
- (c) Each facility's operating margin for the three-year period shall be calculated by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, with the result expressed as a percentage. For hospital-based RHCFS for which an operating margin cannot be calculated on the basis of the submitted cost reports, the sponsoring hospital's overall three-year operating margin, as reported in the institutional cost report, shall be utilized for this purpose. All facilities with negative operating margins calculated in this way over the three-year period shall be arrayed into quartiles based on the magnitude of the operating margin. Any facility with a positive operating margin for the most recent three-year period, a negative operating margin that places the facility in the quartile of facilities with the smallest negative operating margins, a positive total margin in the most recent year of the three-year period or an average Medicaid utilization percentage of 50% or less during the most recent year of the three-year period shall be disqualified from receiving an adjustment pursuant to this section.
- (d) For each facility remaining after the exclusions made pursuant to paragraph (c) of this section, the Commissioner of Health shall calculate the average annual operating loss for the three-year period by subtracting total operating expenses for the three-year period from

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total operating revenues for the three-year period, and dividing the result by three. For this purpose, for hospital-based RHCFS for which the average annual operating loss cannot be calculated on the basis of submitted cost reports, the sponsoring hospital's overall average annual operating loss for the three-year period shall be apportioned to the RHCf based on the proportion the RHCf's total revenues for the period bears to the total revenues reported by the sponsoring hospital.

(e) Each such facility's qualifying operating loss shall be determined by multiplying the facility's average annual operating loss for the three-year period as calculated pursuant to paragraph (d) of this section by the applicable percentage shown in the tables below for the quartile in which the facility's negative operating margin for the three-year period is assigned.

(i) For a facility located in a county with a total population of 200,000 or more as determined by the 2000 U.S. Census:

<u>First Quartile (lowest operating margins):</u>	<u>30 percent</u>
<u>Second Quartile</u>	<u>15 percent</u>
<u>Thlrd Quartile</u>	<u>7.5 percent</u>

(ii) For a facility located in a county with a total population of fewer than 200,000 as determined by the 2000 U.S. Census:

<u>First Quartile (lowest operating margins):</u>	<u>35 percent</u>
<u>Second Quartile</u>	<u>20 percent</u>
<u>Thlrd Quartile</u>	<u>12.5 percent</u>

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- (f) The amount of any facility's financially disadvantaged RHCF distribution calculated in accordance with this section shall be reduced by the facility's rate year benefit of the 2001 update to the regional input price adjustment factors, if any. After all other adjustments to a facility's financially disadvantaged RHCF distribution have been made in accordance with this section, the amount of each facility's distribution shall be limited to no more than \$400,000 during the period October 1, 2004 through December 31, 2004 and during any subsequent annual rate period.
- (g) The adjustment made to each qualifying facility's Medicaid rate of payment determined pursuant to the section shall be calculated by dividing the facility's financially disadvantaged RHCF distribution calculated in accordance with this section by the facility's total Medicaid patient days reported in the cost report submitted two years prior to the rate year, provided however, that such rate adjustments for the period October 1, 2004 through December 31, 2004, shall be calculated based on twenty-five percent of each facility's reported total Medicaid patient days as reported in the applicable 2002 cost report. Such amounts will not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.
- (h) The total amount of funds to be allocated and distributed for financially disadvantaged RHCF rate adjustments to eligible facilities for a rate period in accordance with this section shall be thirty million dollars for the period October 1, 2004 through December 31, 2004 and thirty million dollars for annual rate periods on and after January 1, 2005. In the event the statewide total of the rate adjustments determined pursuant to paragraph (g) of this section varies from thirty million dollars, for the period October 1, 2004 through December 31, 2004, or for any annual period thereafter, each qualifying facility's rate adjustment shall be proportionately increased or decreased such that the total rate adjustments made pursuant to this section is equal to thirty million dollars on a statewide basis.

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86-2.11 - Adjustments To Direct Component Of The Rate:

(a) Payments for 1986 and subsequent rate years for the Direct Component of the rate as defined in subdivision (c) of section 2.10 of this Subpart shall be adjusted periodically as described in this section to reflect changes in the case mix of facilities.

(b) Facilities shall report to the department changes in patient case mix follows:

(1) Full Reassessments: Facilities shall, on a schedule to be established by the department, assess all their patients semi-annually and submit patient review instruments pursuant to section 86-2.30 of this Subpart. The department shall consider, in developing such schedule, that for each of the six months in a semi-annual period, there would be submitted approximately 1/6 of the assessments for all patients in the state.

(2) Assessment of patients admitted since the last assessment period: Three months from the date facilities are scheduled to perform full reassessments, facilities shall assess patients admitted and still residing in the facility since the last full assessment period. Patient review instruments for such patients shall be submitted pursuant to section 86-2.30 of this Subpart on a schedule to be established by the department. The department shall consider, in developing such schedule that for each six months in a semi-annual period, there would be submitted approximately 1/6 of the assessments of such new admissions.

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supersedes  
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(3) Notification to department of patients discharged since last assessment period: Facilities shall notify the department of any patients assessed during the previous full reassessment period as described in paragraph one of this subdivision and since discharged concurrent with the submissions required by paragraph (2) of this subdivision for patients admitted since the last assessment period.

(c) Payment Rates for the Direct Component of the rate as defined in subdivision (c) of section 86-2.10 of this Subpart shall be adjusted, on a facility specific basis for changes in patient case mix retroactive to the beginning date of the month in which the assessment of patients was scheduled by the department and performed by the facility.

(d) Adjusted payment rates shall be determined by recalculating a facility's number of patients in each patient classification group as a result of the submissions in accordance with this section and such results shall be used in the calculation of the facility specific direct adjusted payment price per day pursuant to paragraph four of subdivision (c) of section 85-2.10 of this Subpart.

(e) Trending: Payment rates for the operating component of the rate as defined in paragraph (2) of subdivision (b) of section 85-2.10 of this Subpart may be adjusted for changes in the trend factors originally promulgated by the department in accordance with section 86-2.12 of this Subpart.

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(a) The operating cost component of residential health care facilities (RHCF's) rates of payment effective for the January 1, 2007 through December 31, 2007 and January 1, 2008 through December 31, 2008 rate periods, respectively, shall consist of the sum of the Direct, Indirect and Non-Comparable components of the rate

(1) in effect as of October 1, 2006 and adjusted for inflation to the 2007 rate period;

(2) in effect as of December 31, 2006 and adjusted for inflation to the 2008 rate period;

(3) the rates shall be further adjusted as follows:

i. a per diem add-on reflecting the proportional amount of each facility's projected Medicaid benefit to total Medicaid benefit for all facilities of the imputed rate methodology to be effective [January 1] ~~April 1~~, 2009, including use of the allowable operating costs as reported in each facility's 2002 calendar year cost report, adjusted for inflation to the applicable rate period and reflecting the expiration of the productivity and efficiency limitation and the fiscal and administrative cap adjustments; and

ii. for those facilities which do not receive a benefit from the incorporation of 2002 allowable operating costs, rates for 2007 and 2008 shall be adjusted by a per diem add-on reflecting a proportional benefit of the expiration of the productivity and efficiency limitation and the fiscal and administrative cap adjustments.

(4) aggregate Medicaid payments for the rate adjustments as stated in (i) and (ii) of paragraph (3) of this section will not exceed \$137.5 million for the 2007 rate period, and \$167.5 million for the 2008 rate period.

(b) Additionally, the rates effective January 1, 2007 and January 1, 2008 shall

(1) include any revisions to the 2006 rates occurring on and after January 1, 2007. Such revisions shall be incorporated into the 2007 and 2008 rate periods on an annual basis on or about November 30, 2007 and November 30, 2008, respectively. These rate adjustments shall be made on a retroactive and prospective basis;

(2) include the cost of local property taxes and payments made in lieu of local property taxes as reported in each facility's cost report for the period two years prior to the rate period;

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- (3) not be subject to case mix adjustments; however, a facility may request such adjustment for increased case mix equal to or greater than .05 if such facility submits supporting documentation based on a full house schedule of patient review instruments, and continues to do so in accordance with its existing submission schedule for rate periods through December 31, 2008.
- (c) Voluntary not-for-profit facilities shall not be required to deposit reimbursement received for depreciation expense into a segregated depreciation account for periods on and after January 1, 2007.
- (d) Effective [January] April 1, 2009, the operating component of rates of payment shall consist of the sum of the Direct, Indirect and Non-Comparable components based on allowable operating costs and statistical data as reported in each facility's cost report for the 2002 calendar year, adjusted for inflation on an annual basis.
- (1) For facilities which do not benefit from the use of 2002 cost report data, the operating component of the rates shall not be less than the operating component in effect for the 2008 rate period, adjusted for inflation on an annual basis.
- (2) For facilities with an operating cost component which is based on allowable costs from a calendar year cost report subsequent to 2002, the rates shall remain on such costs.
- (3) Effective for the period January 1, 2007 through December 31, 2011, appointment of a receiver, establishment of a new operator, or replacement or renovation of an existing facility that occurs on or after January 1, 2007, shall not result in a revised operating component of the rates unless an application for these changes is filed with the Department of Health by December 31, 2006, which is subsequently approved and which otherwise meets existing Department criteria for the establishment of a new base year for rate-setting purposes.

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- (5) Cost reports submitted by facilities for the 2002 calendar year or any subsequent year used to determine the operating component of the 2009 rate shall be subject to audit through December 31, 2014. Facilities will therefore retain all fiscal and statistical records relevant to such costs reports. Any audit of the 2002 cost report, which is commenced on or before December 31, 2014, may be completed subsequent to that date and used for adjusting the Medicaid rates that are based on such costs.
- (e) Additionally, the operating component of the rates effective [January] April 1, 2009 shall
- (1) be subject to a case mix adjustment through application of the relative [r]Resource [u]Utilization [g]Groups [s]System (RUGS-III) used by the federal government for Medicare, [and] revised [by state regulation] to reflect NYS wage and fringe benefits, and based on Medicaid only patient data. New York State wages are used to determine the weight of each RUG. The cost for each RUG is calculated using the relative resources for registered nurses, licensed practical nurses, aides, therapists, and therapy aides using the 1995 – 97 federal time study. The minutes from the study are multiplied by the NY average dollar per hour to determine the fiscal resources needed to care for that patient type for one day. This amount is multiplied by the number of patients in that RUG. RUG weights are assigned based on the distance from the statewide average. The RUGS-III weights shall be increased for the following resident categories:
- (i) 30 minutes for impaired cognition A;
  - (ii) 40 minutes for impaired cognition B; and
  - (iii) 25 minutes for reduced physical functions B.
- Medicaid only [C]case mix adjustments shall be made in January and July of each calendar year. The adjustments and related patient classifications for each facility shall be subject to audit review in accordance with regulations promulgated by the Commissioner of Health, [;] and effective January 1, 2009 shall
- (2) incorporate the continuation, through 2009 and subsequent years, of the adjustment for extended care of persons with traumatic brain injury in accordance with the provisions of this Attachment;
- (3) incorporate the continuation, through 2009 and subsequent years, of the adjustment for the cost of providing Hepatitis B vaccinations in accordance with the provisions of this Attachment;
- (4) reflect a per diem add-on of \$8, trended from 2006 to 2009 and thereafter, for each patient who:

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- (i) qualifies under both RUG-III impaired cognition and behavioral problems categories; or
  - (ii) has been diagnosed with Alzheimer's disease or dementia and is classified in reduced physical functions A, B or C, or in behavioral problems A or B categories, and also has an activities of daily living index of ten or less;
- (5) reflect a per diem add-on of \$17, trended from 2006 to 2009 and thereafter, for each patient whose body mass index is greater than thirty-five (35);
- (6) reflect the cost of local property taxes and payments in lieu of local property taxes, as reported in each facility's cost report for the period two years prior to the rate year.
- (f) Direct component of the rate.
- (1) allowable costs for the direct component of the rate shall include costs reported in the following functional cost centers on the facility's annual cost report (RHCF-4) or extracted from a hospital-based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending.
- (i) nursing administration;
  - (ii) activities;
  - (iii) social services;
  - (iv) transportation;
  - (v) physical therapy (including associated overhead);
  - (vi) occupational therapy (including associated overhead);
  - (vii) speech therapy (including associated overhead);
  - (viii) central service supply; and
  - (ix) residential health care facility.
- (2) For purposes of calculating the direct component of the rate, the Department shall use the methodology provided in this Attachment, except as provided in subparagraph (3) of paragraph (f) regarding the determination of the allowable cost ceiling:

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- (3) For purposes of computing the cost ceilings for the direct component, facilities shall be organized into peer groups consisting of:
- (i) free-standing facilities with certified bed capacities of less than 300 beds;
  - (ii) free-standing facilities with certified bed capacities of 300 beds or more; and
  - (iii) hospital-based facilities.
- (4) In determining the direct cost component, for each peer group, a corridor shall be developed around the statewide mean direct price per day, provided, however, that the corridor around each mean direct price per day shall have a base no less than eighty-five percent and no greater than ninety percent of each mean direct price per day, and a ceiling no greater than one hundred fifteen percent and no less than one hundred ten percent of each mean direct price per day, and further provided, however, that the total financial impact of the application of the ceiling shall be substantially equal to the total financial impact of the application of the base.
- (5) Public facilities, and non-public facilities with fewer than 80 certified beds, which have a facility specific direct adjusted price per day that is equal to the applicable ceiling shall have such price per day adjusted by an addition of 50% of the difference between the facility specific price per day and the ceiling price per day. The adjustment to the direct price per day shall be increased to the rate year by the applicable inflation factor, and adjusted by the regional direct input price factor.
- (g) Indirect component of the rate.
- (1) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's annual cost report (RHCF-4) or extracted from a hospital based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending:

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- (i) fiscal services;
- (ii) administrative services;
- (iii) plant operations and maintenance (with the exception of utilities and real estate and occupancy taxes);
- (iv) grounds;
- (v) security;
- (vi) laundry and linen;
- (vii) housekeeping;
- (viii) patient food services;
- (ix) cafeteria;
- (x) non-physician education;
- (xi) medical education;
- (xii) housing; and
- (xiii) medical records.

- (2) For purposes of calculating the indirect component of the rate, the Department shall use the methodology provided in this Attachment, except as provided in subparagraph (3) of paragraph (g) regarding the determination of the allowable cost ceiling;
- (3) For purposes of computing the cost ceilings for the indirect component, facilities shall be organized into peer groups consisting of:
  - (i) free-standing facilities with certified bed capacities of less than 300 beds;
  - (ii) free-standing facilities with certified bed capacities of 300 beds or more; and
  - (iii) hospital-based facilities.
- (4) In determining the indirect cost component, for each peer group, a corridor shall be developed around the statewide mean indirect price per day, provided, however, that the corridor around each mean indirect price per day shall have a base no less than eighty-five percent and no greater than ninety percent of each mean indirect price per day, and a ceiling no greater than one hundred fifteen percent and no less than one hundred ten percent of each

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mean indirect price per day, and further provided, however, that the total financial impact of the application of the ceiling shall be substantially equal to the total financial impact of the application of the base.

- (5) Public facilities, and non-public facilities with fewer than 80 certified beds, which have a facility specific indirect adjusted price per day that is equal to the applicable ceiling shall have such price per day adjusted by an addition of 50% of the difference between the facility specific price per day and the ceiling price per day. The adjustment to the indirect price per day shall be increased to the rate year by the applicable inflation factor, and adjusted by the regional indirect input price factor.

(h) Non-comparable component of the rate.

- (1) The non-comparable component of the rate shall consist of costs, which represent allowable costs reported by a facility, which because of their nature are not subject to peer group comparisons.

- (2) Allowable costs for the non-comparable component of the rate shall include the costs associated with supervision of facility volunteers and costs reported in the following functional cost centers as reported on the facility's annual cost report (RHCF-4) or extracted from a hospital based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting capital cost and allowable items not subject to trending:

- (i) laboratory services
- (ii) ECG
- (iii) EEG
- (iv) radiology
- (v) inhalation therapy
- (vi) podiatry
- (vii) dental
- (viii) psychiatric
- (ix) speech and hearing therapy - (Hearing Therapy Only)
- (x) medical director office
- (xi) medical staff services
- (xii) utilization review
- (xiii) other ancillary
- (xiv) plant operations and maintenance - (cost for utilities and real estate and occupancy taxes)
- (xv) pharmacy (including administrative overhead for pharmacy and costs of non-prescription drugs and supplies).

TN #06-39 \_\_\_\_\_

Approval Date JUN 12 2008 \_\_\_\_\_

Supersedes TN New \_\_\_\_\_

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- (i) Capital component of the rate.  
The allowable facility specific capital component of the rate shall include allowable capital costs determined in accordance with §86-2.19, 86-2.20, 86-2.21 and 86-2.22 of this Subpart and costs of other allowable items determined by the Department to be non-trendable divided by the facility's patient days in the base year determined applicable by the Department.
- (j)(1) For rate periods on and after January 1, 2007, no less than 65% of the additional Medicaid reimbursement received by a facility from the proportional add-on related to the projected 2002 reported base year costs, must be used for recruitment and retention of non-supervisory or other direct resident care workers or for purposes authorized under the Quality Improvement Demonstration Program. However, facilities shall not be required to spend more than 75% of the additional Medicaid reimbursement for these purposes.
- (2) The Commissioner of Health is authorized to perform audits of the facilities to ensure compliance with the requirement established in subparagraph (1) of this paragraph (j), and may recoup any amount determined to be used for other purposes. The Commissioner may waive the requirements for this mandatory use of this Medicaid reimbursement on request of a facility, if it is determined that the funds are not available for these purposes because they have been used to correct deficiencies at a facility that constitute a threat to resident safety.
- (k) For the rate periods after 2009 which utilize reported costs from a base year subsequent to 2002, the following categories of facilities shall receive rates that are no less than the rates that were in effect for such facilities on December 31, 2006, trended to the applicable rate year:
- (1) AIDS facilities or discrete AIDS units;
  - (2) discrete units for residents on long-term inpatient rehabilitation for traumatic brain injury;
  - (3) long-term ventilator discrete units;
  - (4) discrete units providing specialized programs for residents requiring behavioral interventions; and
  - (5) facilities or discrete units that provide extensive nursing, medical, psychological and counseling services solely for children.

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(c) Beginning April 1, 1991, the commissioner, in accordance with the methodology developed pursuant to subdivisions (d), (e) and (f) of this section, shall establish trend factors for residential health care facilities to project allowable cost increases for the effects of inflation during the effective period of the reimbursement rate. The allowable basic rate prior to the addition of capital costs and depreciation and interest related to movable equipment shall be trended, beginning on April 1, 1991, to the applicable rate year by the trend factors developed in accordance with subdivisions (d) through (f) of this section.

(d) The methodology for developing the trend factors shall be established by a panel of four independent consultants with expertise in health economics appointed by the commissioner.

(e) The methodology for developing the trend factors shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for nonsupervisory employees.

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(f)(1) On or about September first of each year, the consultants shall provide to the Commissioner and the State Hospital Review and Planning Council, the methodology to be used to determine the trend factors for the rate period, commencing on the next January first. The Commissioner shall monitor the actual price movements during these periods of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants and shall implement the recommendations of the consultants for one prospective interim annual adjustment to the initial trend factors to reflect such price movements and to be effective on January first, one year after the initial trend factors were established.

(2) Notwithstanding the dates specified in paragraph (1), the consultants shall provide as soon as possible to the Commissioner and the State Hospital Review and Planning Council, the methodology to be used to determine the trend factor for the rate period April 1, 1991 to December 31, 1991. One prospective interim annual adjustment for this rate period shall be made on January 1, 1992 and one prospective final annual adjustment for this rate period shall be made January 1, 1993.

(3) for rate periods on and after April 1, 2000, the commissioner shall establish trend factors for rates of payment for state governmental agencies to project for the effects of inflation. The factors shall be applied to the appropriate portion of reimbursable costs.

(a) In developing trend factors for such rates of payment, the commissioner shall use the most recent Congressional Budget Office estimate of the rate year's U.S. Consumer Price Index for all urban consumers published in the Congressional Budget Office Economic and Budget Outlook after June first of the rate year prior to the year for which rates are being developed.

(b) After the final U.S. Consumer Price Index (CPI) for all urban consumers is published by the United States Department of Labor, Bureau of Labor Statistics, for a particular rate year, the commissioner shall reconcile such final CPI to the projection used in subparagraph (a) of this paragraph and any difference will be included in the prospective trend factor for the current year.

(c) At the time adjustments are made to the trend factors in accordance with this paragraph, adjustments shall be made to all inpatient rates of payment affected by the trend factor adjustment.

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APR 01 2000

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- (g) For reimbursement of services provided to patients for the period April 1, 1995 through December 31, 1995, the trend factors established in accordance with subdivisions (d), (e) and (f) of this section shall reflect no trend factor projections applicable to the period January 1, 1995 other than those reflected in 1994 rates of payment and provide further, that this subdivision shall not apply to use of the trend factor for the January 1, 1995 through December 31, 1995 period, any interim adjustment to the trend factor for such period, or the final trend factor for such period for purposes of projection of allowable operating costs to subsequent rate periods. The Commissioner of Health shall adjust such rates of payment to reflect the exclusion of trend factor projections pursuant to this subdivision. For reimbursement of services provided to patients effective April 1, 1996 through March 31, 1997, the rates will be established by the Commissioner of Health without trend factor adjustments, but shall include the full or partial value of the retroactive impact of trend factor final adjustments for prior periods.\* For reimbursement of services provided to patients on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, [2009] 2011, the rates shall reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.
- (h) For reimbursement of nursing home services provided to patients beginning on and after April 1, 2006 through March 31, 2011, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.
- (i) For reimbursement of nursing home services provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor equal to 75% of the otherwise applicable trend factor for calendar year 2007 as calculated in accordance with paragraph (f) of this section.
- (j) For reimbursement of nursing home services provided on and after April 1, 2008, except for the nursing facilities which provide extensive nursing, medical, psychological, and counseling support services to children, the Commissioner of Health shall apply a trend factor equal to 65% of the otherwise applicable trend factor for calendar year 2008 as calculated in accordance with paragraph (f) of this section.

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Supersedes TN           #08-24          

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- (k) For rates of payment effective for nursing home services provided on and after January 1, 2009 through March 31, 2009, the otherwise final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3% and no retroactive adjustment to such 2008 trend factor shall be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be zero.
- (l) For rates of payment effective for nursing home services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, as calculated in accordance with paragraph (f) of this section, less 1% shall be applied. Effective on and after April 1, 2009, the otherwise applicable trend factor attributable to the 2009 calendar year period shall be zero.
- (m) For rates of payment effective for nursing home services provided for the period January 1, 2010 through March 31, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period shall be zero.
- (n) For rates of payment effective for inpatient services provided by residential health care facilities [nursing home services provided] on or after April 1, 2010, except for residential health care facilities that provide extensive nursing, medical, psychological, and counseling support services to children, the otherwise applicable trend factor attributable to the 2010 calendar year period shall be zero.

Effective July 1, 1994, payment rates for the 1994 rate setting cycle will be calculated using the proxy data described in this section that is available through the third quarter of 1993. Proxy data, which becomes available subsequent to the third quarter of 1993, will not be considered in setting or adjusting 1994 payment rates.

\*This means that since the rates for the April 1, 1996 through March 31, 1997 period are based on 1983 base year costs trended to this period, the rate impacts of any differences between, say, the final value of the 1995 trend factor and the preliminary 1995 trend factor value that may have been used when initially calculating the rate, would be incorporated into the rates for the April 1, 1996 through March 31, 1997 rate period.

TN #10-12 \_\_\_\_\_

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Supersedes TN #09-68 \_\_\_\_\_

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### TREND AND ROLL FACTORS:

The authorization of an independent Panel of Health Economists to develop trend factors used in the residential health care facility reimbursement methodology is contained in statute. The following [are] is a summary of the major components of the trend factors methodology as adopted by the Panel of Health Economists.

The actual proxies used in the calculation of the trend factors are listed in p.51(c)(d)(e) and (f). The proxies adopted by the Panel as listed in p.51(c)(d)(e) and (f) may change back to the beginning of the year when data upon which a proxy is based becomes unavailable or by recommendation of the Panel of Health Economists who statutorily are authorized to determine the trend factor methodology.

#### Projection Methodologies

Labor - In order to quantify the labor price movement component of the trend factor, national proxies are used, adjusted by a Regional Adjustment Factor (RAF) to estimate New York State experience. These proxies are weighted to produce a composite labor price movement. In calculating the initial and revised trend factors for a given year, a projection methodology for the labor price movements is used since actual data for the year are not yet available. The projections are based on the compounding of quarterly increases in the proxies for the four latest available quarters of data. The final trend factor calculations are based on actual proxy data for the trend factor year compared to the preceding year.

All but one of the [some] labor proxies measure increases in compensation and therefore reflect changes in both salaries and fringe benefits. The labor [proxies] proxy which measures only changes in wages and salaries [are] is adjusted by a Compensation Factor (the ration of the percent change in the Employment Cost Index-Compensation to the Employment Cost Index-Wages and Salaries) [for the appropriate series] to incorporate fringe benefits changes.

Non-Labor - A number of different proxies are used to measure price movements in non-labor [related] expenses incurred by facilities. In calculating the initial and revised trend factors, an estimate of the non-labor price movement is made based upon the projection of the GDP [GNP] Implicit Price Deflator. The final trend factor calculations are made using the actual changes in the non-labor proxies.

TN. 94-04

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ITEM	PROXY
Labor	
Executive, Administrative and Managerial Personnel	ECI-Civilian-Compensation-Health-Services - Executive, Administrative and Managerial 1/
Professional and Technical Personnel	ECI-Civilian-Compensation-Service-Producing-Industries-Service-Occupation 41.1% 1/ Professional and Technical 1/
All Other Personnel	1. ECI-Civilian-Compensation-Service-Producing-Industries-Service-Occupation 41.1% 1/ 2. ECI-Civilian-Compensation-Service-Producing-Industries-Clerical 45.0% 1/ 3. ECI-Civilian-Compensation-Service-Producing-Industries-Blue Collar 8.9% 1/ 4. ECI-Compensation-Private Industry-Workers-Union-Service-Producing Industries 5.0% 1/ Collective-bargaining-Agreements-Service-Producing-Industries 5.0% 2/ a. ECI-Compensation-Private-Industry-Service-Producing-Industries 3/ b. ECI-Wages-and-Salaries-Private-Industry-Service-Producing-Industries 3/
Regional Adjustment Factor	Average hourly earnings industry composite-New York and U.S.-50% CPI-U-New York City Area, Buffalo Area, Northeast Size b, Northeast Size C. U.S.-50%
Non-Labor	
Telephone	Telephone rate index
Insurance - Malpractice, general liability, umbrella & other	Weighted average percent change in insurance cost

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AUG 3 2000  
 AUG 3 1999

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Legal Services	ECI-Compensation-Private Industry Workers-Professional Specialty & Technical 1/
Auditing Services	ECI-Compensation-Civilian Private Industry Workers -Executive, Administrative and Managerial 1/
Office Supplies	<ol style="list-style-type: none"> <li>1. Office Supplies &amp; Accessories (PPI) - <del>(15%)</del> 40%</li> <li>2. <del>Unwatermarked Bond, #4 (PPI) 35%</del></li> <li>3. <del>Form Bond, 15 lb. (PPI) 30%</del></li> <li>4. <del>ECI-Compensation-Private Industry Workers-Executive, Administrative and Managerial 20% 1/1</del></li> <li>2. Office Machines NEC - 12.5% (PPI)</li> <li>3. Writing and Printing Papers - 20% (PPI)</li> <li>4. Pens, Pencils and Marking Devices - 12.5% (PPI)</li> <li>5. Classified Advertising - 7.5% (PPI)</li> <li>6. Periodicals, Circulation - 7.5% (PPI)</li> </ol>
Management Consulting Fees	<p>Average hourly earnings - Management and Public Relation Services 2/            a. ECI Private Industry Workers - Compensation - Executive, Administrative and Managerial 3/            b. ECI - Private Industry Workers - Wages and Salaries - Executive, Administrative and Managerial 3/</p>
Interest Expense - Working Capital	Predominant prime time
Real Estate Taxes	<ol style="list-style-type: none"> <li>1. NYC tax rates</li> <li>2. Upstate overall tax rate</li> </ol>
Dietary	<ol style="list-style-type: none"> <li>1. All Foods (PPI) - 40%</li> <li>2a. Food at Home, U.S. City average (CPI) or</li> <li>2b. Food at Home, NY-NENJ (CPI) - 40%</li> <li>3. Cups and Liquid - Tight Containers (PPI) - 3%</li> <li>4. Tableware, Serving Pieces, and Nonelectric Kitchenware (CPI) - 7%</li> <li>5a. Food Away From Home, (CPI) U.S. City average or</li> <li>5b. Food Away From Home, NY-NENJ (CPI) - 10%</li> </ol>
Maintenance & Repairs	Maintenance & Repairs (CPI)

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ITEM	PROXY
● #2 Fuel oil	Price, Tank Car Reseller, NYC & Albany
● #6 Fuel oil	Price, Tank Car Reseller, NYC & Albany
● Natural Gas	NYSDDS data for Brooklyn Union, Central Hudson, Columbia Gas, Con-Ed, L.I. Lighting, National Fuel Dist., Niagara Mohawk, NYS Electric & Gas, Orange & Rockland, Rochester Gas & Electric
● Electric Power	NYSDDS price index for Con-Ed, L.I. Lighting, Orange & Rockland, Central Hudson, NYS Electric & Gas, Niagara Mohawk, Rochester Gas & Electric
● Water and Sewer	Water and Sewerage Maintenance (CPI)
● Disposable Linen	Disposable Diapers (PPI)
● Linen and Bedding	Textile House furnishings (CPI)
● Housekeeping	Housekeeping Supplies (CPI)
● Maintenance and Repairs Other Utilities	Maintenance and Repairs (CPI)

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ITEM	PROXY
• Drugs	1. Preparations, Ethical (Prescription) (PPI) - 72.0% 2. Preparation, Prop. (Over the Counter) (PPI) - 5.0% 3. Prescription Drugs (CPI) - 23.0%
• Medical Supplies	1. Medical Instruments and Apparatus - (PPI)
• Physicians Fees	Physicians' Services (CPI) 4/
• Other Health Personnel Fees	ECI - Compensation - Private Industry Workers - Professional Specialty and Technical 1/

- 1/Includes Regional Adjustment Factor
- 2/Includes Regional Adjustment Factor and Compensation Factor
- 3/Excludes Regional Adjustment Factor
- 4/Includes Regional Adjustment Factor and Excludes Compensation Factor

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86-2.13 Adjustments to provisional rates based on errors. (a) Errors resulting from submission of fiscal and statistical information by a residential health care facility may be corrected if brought to the attention of the State Commissioner of Health within 120 days of receipt of the commissioner's initial rate computation sheet. Errors on the part of the State Department of Health resulting from the rate computation process may be corrected if brought to the attention of the commissioner within 120 days of receipt of the commissioner's initial rate computation sheet. Subsequent errors on the part of the State Department of Health resulting from the revision of a rate may be corrected if brought to the attention of the commissioner within 30 days of receipt of the commissioner's revised rate computation sheet. In no event, however, shall a facility have less than 120 days from receipt of the initial rate computation sheets to bring errors to the attention of the commissioner.

(b) Rate appeals pursuant to this section, if not commenced within 120 days of receipt of the commissioner's initial rate computation sheet, may be initiated at time of audit of the base year cost figures at or prior to the audit exist conference. Such rate appeals shall be recognized only to the extent that they are based upon errors in the cost and/or statistical data submitted by the residential health care facility, or by revisions initiated by a third-party fiscal intermediary, or in the case of a governmental facility, by the sponsor government or errors made by the Department of Health.

86-4

*supersedes*

82-30

*Approval Date* JUL. 29 1987 *Effective Date* JAN. 1 1988

86-2.14 Revision in Certified Rates. (a) The State Commissioner of Health may consider only those applications for revisions of certified rates which are based on:

(1) cost reports filed pursuant to subdivision (e) of section 86-2.2 of this Subpart. Such rate shall become effective on the first day of the [six-month] twelve-month period referred to in section 86-2.2(e) of this Subpart;

(2) six-month cost reports filed pursuant to sections 86-2.10(k)(6) and/or 86-2.15(e). Such rate shall become effective on the first day of the six-month period referred to in sections 86-2.10(k)(6) and 86-2.15(e) of this Subpart;

~~[(2)]~~(3) errors made by the Department in the rate calculation process and errors in data submitted by a medical facility which have been brought to the attention of the commissioner within the time limits prescribed in section 86-2.13 of this Subpart. This paragraph shall not apply to the patient assessment process as contained in section 86-2.30 of this Subpart;

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[(3)](4) significant increases in overall operating costs of a residential health care facility resulting from the implementation of additional programs or services specifically mandated for the facility by the commissioner;

[(4)](5) significant increases in the overall operating costs of a residential health care facility resulting from capital renovation, expansion, replacement or the inclusion of new programs or services approved for the facility by the commissioner;

[(5)](6) request for waivers of any provisions of this Subpart for which waivers may be granted by the commissioner as prescribed in specific sections; [and]

[(6)](7) alternative means of allocating costs in the cost-finding process which have been submitted with the annual cost report (RHCF-4c) and approved [in accordance with Section 456.2(b) and (c)]; and

[(7)](8) requests for relief from the provisions of section 86-2.25 of this Subpart relating to compensation of other than the administrative type of services rendered by an operator or relative of an operator. Such requests must contain sufficient documentation to demonstrate

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that the services rendered are necessary and are reasonably related to the efficient production of such services.

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TN 93 - 04 <sup>is</sup> Approval Date JUL 24 1996  
Supersedes TN New Effective Date APR 1 - 1993

(b) An application by a residential health care facility for review of a certified rate is to be submitted on forms provided by the Department and shall set forth the basis for the appeal and the issues of fact. Documentation shall accompany the application, where appropriate, and the Department may request such additional documentation as determined necessary. An application based upon error shall be submitted within the time limit set forth in section 86-2.13 of this Subpart. Beginning with appeals for rate year 1983 and, on an annual basis thereafter for all subsequent rate year appeals, the Commissioner shall act upon all properly documented applications for a rate year based upon errors within one year of the end of the 120-day period referred to in section 86-2.13(a) of this Subpart. The Commissioner shall act upon all other properly documented applications for a rate year

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appeal submitted pursuant to paragraphs (1) and (3) - (7) of subdivision (a) of this Subpart within one year of the aforementioned 120-day period or the receipt of such applications, whichever date is later. In the event the Department requests additional documentation, the one year time limit shall be extended for a mutually agreed upon time period for receipt of the documentation established by the Commissioner in conjunction with the residential health care facility. The deadline will be set according to the nature and quantity of documentation necessary. The one-year time limit shall not apply to rate appeals submitted pursuant to section 86-2.13(b) of this Subpart.

(1) The affirmation or revision of the rate upon such staff review shall be final, unless within 30 days of its receipt a hearing is requested, by registered or certified mail, before a Rate Review Officer on forms supplied by the Department. The request shall contain a statement of factual issues to be resolved. The facility may submit memoranda on legal issues which it deems relevant to the appeal.

(2) Where the Rate Review Officer determines that there is no factual issue, the request for a hearing shall be denied and the facility notified of such determination. The Rate Review Officer, where he determines that there is factual issue, shall issue a notice of hearing establishing the date, time and place of the hearing and setting forth the factual issues as determined by such Officer. The hearing shall be held in conformity with the provisions of the Public Health Law section 12-a and the State Administrative Procedure Act.

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supersedes  
83-7 + 82-30

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(3) The recommendation of the rate Review Officer shall be submitted to the commissioner of Health for final approval or disapproval and recertification of the rate where appropriate.

(4) The procedure set forth in this subdivision shall apply to all applications for rate reviews which are pending as of April 1, 1978. Rate appeals filed prior to April 1, 1978, will not be required to be resubmitted subsequent to April 1, 1978.

(c) Any modified rate certified under paragraph (3) and (4) of subdivision (a) of this section shall be effective on the first day of the month in which the respective change is operational.

(d) In reviewing appeals for revisions to certified rates the commissioner may refuse to accept or consider an appeal from a residential health care facility:

(1) providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council;

(2) operated by the same management when it is determined by the department that this management is providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council in one of its facilities;

(3) where it has been determined by the commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law;

(4) where a fine or penalty has been imposed on the facility and such fine or penalty has not been paid.

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In such instances the provisions of subdivision (c) of this section shall not be effective until the date the appeal is accepted by the commissioner.

(e) Any residential health care facility determined after review by the State Hospital Review and Planning Council to be providing an unacceptable level of care shall have its current reimbursement rate reduced by 10 percent as of the first day of the month following 30 days after the date of the determination. This rate reduction shall remain in effect for a one-month period or until the first day of the month following 30 days after a determination that the level of care has been improved to an acceptable level, whichever is longer. Such reductions shall be in addition to any revision of rates based on audit exceptions.

(f) Reserved.

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supersedes  
82-30

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86-2.15 Rates for residential health care facilities without adequate cost experience.

(a)(1) This subdivision shall apply where the fiscal and statistical data of the facility are unavailable through no fault of the provider or its agents, and due to circumstances beyond its control, or when there is a new facility without adequate cost experience as set forth in subdivision (e) of section 86-2.2 of this Subpart.

(2) The appointment of a receiver or the establishment of a new operator for an ongoing facility shall not be considered a new facility for the purposes of this section. Reimbursement for such receiver or new operator shall be in accordance with sections 86-2.10 and 86-2.11 of this Subpart.

(b) The rates certified for such residential health care facilities as set forth in subdivision (a) of this section, shall be determined in accordance with the following:

(1) Except as identified in paragraph (5) (6) and (7) of this subdivision, for the first three months of operation, the direct component of the rate shall be equivalent to the statewide [base] mean direct case mix neutral cost per day after application of the RDIPAF as determined pursuant to section 86-2.10 of this Subpart. The facility shall perform an assessment of all patients, pursuant to section 86-2.30 of this Subpart, at the beginning of the fourth month of operation and at the beginning of each third

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month thereafter until the end of the [six-month] twelve-month cost report period referred to in section 86-2.2(e) of this Subpart or if applicable, the six-month cost report identified in subdivision (e) of this section. The direct component of the rate shall be adjusted pursuant to section 86-2.10 of this Subpart, effective the first day of the month of each assessment period, based on the facility's case mix.

(2) Except as identified in paragraph (5), (6) and (7) of this subdivision, for the first three months of operation, the indirect component of the rate shall be equivalent to a blended [base] mean price for the applicable affiliation group as identified in subdivision (d) of section 86-2.10 of this Subpart. The blended [base] mean price shall be established using a proportion of 60 residents in the high case mix index peer group and 40 residents in the low case mix index peer group both as identified in subdivision (d) of 86-2.10 of this Subpart, adjusted by the RIIPAF. Effective on the first day of the fourth month the indirect component shall be the [base] mean price determined using the facility's PRI's and adjusted by the RIIPAF.

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(3) the non-comparable component of the rate shall be determined on the basis of generally applicable factors, including but not limited to the following:

- (i) satisfactory cost projections;
- (ii) allowable actual expenditures;
- (iii) an anticipated average utilization of no less than 90 percent.

(4) Rates established pursuant to this subdivision shall also include an adjustment pursuant to subdivision (u) of section 86-2.10 of this Subpart.

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(5) Acquired Immune Deficiency Syndrome (AIDS). Except as identified in subparagraph (v) of this paragraph, a facility which is approved as a distinct AIDS facility or has a discrete AIDS unit pursuant to Part 710 of this Title, shall have rates established pursuant to this subdivision as follows:

(i) The direct component of the rate shall be determined in accordance with paragraph (1) of this subdivision provided, however, that the direct [base] mean [price] rate for the first three months of operation shall be determined pursuant to an approved facility's projection of case mix. The direct component of the rate shall be enhanced by an increment which shall be determined on the basis of the difference between budgeted costs of care and staffing levels for AIDS patients in specific patient classification groups and the costs of care and staffing levels for non-AIDS patients which are classified in the same patient classification groups based on data submitted by a facility. The increment to be included in the facility's rate pursuant to this subparagraph shall be approved by the commissioner, but in no event shall the increment be greater than 1.0. The direct component of the rate shall also be increased by an occupancy factor of 1.225.

(ii) The indirect component shall be determined in accordance with paragraph (2) of this subdivision provided however, that the indirect [base] mean price for the first three months of operation shall be determined pursuant to an approved facility's projection of case mix. The indirect component of the rate shall be increased by the AIDS factor as determined pursuant to section 86-2.10(p) of this Subpart.

(iii) The allowable costs for the central service supply functional cost center as listed in paragraph (1) of section 86-2.10(c) shall be considered as a non-comparable cost.

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(iv) Rates developed pursuant to this paragraph shall remain in effect until a facility submits twelve-month financial and statistical data pursuant to subdivision (e) of section 86-2.2 of this Subpart.

(v) Notwithstanding the provisions of subparagraph (i), (ii) and (iii) of this paragraph, any facility which prior to April 1, 1991 has a rate approved and certified by the commissioner pursuant to section 2807 of the Public Health Law, which includes AIDS specific adjustments pursuant to this Subpart, or has been approved as an AIDS specific facility by the Public Health Council, and/or has had a certificate of need application approved or conditionally approved pursuant to Part 710 of this Title for the operation of a discrete AIDS unit shall have its rate determined in accordance with the following:

(a) The direct component of the rate shall be based on the statewide ceiling direct case mix neutral cost per day after application of the RDIPAF as determined pursuant to section 86-2.10 of this Subpart and a case mix proxy for AIDS patients established by the subparagraph, and increased by an occupancy factor of 1.225. The case mix proxy for AIDS patients shall be determined as follows:

(1) A facility which was approved based on a written application for establishment and/or construction which indicated that a majority of its AIDS patients would fall into patient classification groups with a case mix index exceeding 0.83 prior to application of any AIDS factors or increments identified in this subdivision shall be assigned a case mix proxy as determined by the following:

(i) For its first three months of operation, the facility shall be assigned a case mix proxy of 2.32.

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(ii) The indirect component of the rate for facilities identified in subclause (2) of this clause shall be equivalent to the ceiling indirect price per day of the low intensity peer group established pursuant to paragraph (2) of subdivision (d) of section 86-2.10 of this Subpart after application of the RIIPAF as determined pursuant to section 86-2.10 of this Subpart and increased by the indirect AIDS factor as determined pursuant to subdivision (p) of section 86-2.10 of this Subpart.

(4) For purposes of this subparagraph, the allowable costs for the central service supply functional cost center as listed in paragraph (1) of section 86-2.10(c) shall be considered a non-comparable cost.

(5) Rates developed pursuant to this subparagraph shall remain in effect until a facility submits financial and statistical data pursuant to section 86-2.2(e) of this Subpart[, but for a period not to exceed 18 months from the effective date of such rate, or April 1, 1991 whichever is later. If a rate pursuant to subdivision (e) of section 86-2.2 of this Subpart cannot be established within this 18 month period, a facility shall have the operational component of its rate determined pursuant to subparagraphs (i), (ii), and (iii) of this paragraph which will be effective on the first day of the month following the 18 month period referenced in this subclause].

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(c) The rates developed pursuant to this section shall remain in effect until a facility submits a twelve-month cost report in accordance with Section 86-2.2(e) of this Subpart for a twelve-month period during which the facility had an overall average utilization of at least 90 percent of bed capacity. This cost report shall be used to adjust the direct, indirect, noncomparable and capital components of the rate effective on the first day of the cost report. However, for a facility that did not or does not achieve 90 percent or greater overall average utilization for any year within 5 calendar years from the date of commencing operation, the rates will be recalculated utilizing the facility's most recently available reported allowable costs divided by patient days imputed at 90 percent. Such recalculated rates shall be effective January 1 of the 6<sup>th</sup> calendar year following the date the facility commenced operations, or April 1, 2006, whichever is later.

(d) All rates of reimbursement certified pursuant to this section shall be subject to audit pursuant to Section 86-2.7 of this Subpart. After audit, the facility shall receive a rate based upon actual allowable costs incurred during the rate period and computed in accordance with Section [96] 86-2.10 of this Subpart. Except as described in Section 86-2.19(d)(2) of this Subpart, an occupancy rate of not less than 90 percent shall be used when calculating the capital and noncomparable components in rate calculation.

(e) Notwithstanding the provisions of this section, an operator of a facility which has had an overall average utilization of at least 90 percent of bed capacity for a six-month period which began prior to April 1, 1993, but after the date on which the operator began operations shall submit a six-month cost report for that period. Such six-month cost report shall be utilized for purposes of this section in lieu of the twelve-month cost report identified in subdivision (e) of Section 86-2.2 of this Subpart.

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(6) Long-term inpatient rehabilitation program for traumatic brain-injured residents (TBI). A facility which is approved to operate discrete units for the care of residents under the long-term inpatient rehabilitation program for TBI patients shall have separate and distinct payment rates established pursuant to this subdivision as follows:

(i) For the first three months of operation, the direct component shall be equivalent to the statewide mean direct case mix neutral cost per day established pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of section 86-2.10 increased by a factor of 3.28 and adjusted by the RDIPAF pursuant to section 86-2.10. The direct component shall be further increased by an occupancy factor of 1.225 for the first six months of operation. The facility shall perform an assessment of all residents, pursuant to section 86-2.30, at the beginning of the fourth month of operation and at the beginning of each third month for the period set forth in paragraph 1 of this subdivision. Effective on the first day of the month of each assessment period, the direct component of the rate shall be adjusted pursuant to subdivision (c) of section 86-2.10 based on the facility's case mix. The case mix index which is used to establish the facility specific mean direct price per day for each patient classification group pursuant to

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paragraph (4) of subdivision (c) of section 86-2.10 for TBI residents shall be increased by an increment of 1.49.

(ii) The indirect component of the rate shall be equivalent to the mean indirect price developed pursuant to section 86-2.10(d) of this Subpart for the applicable peer group established for high intensity case mix identified in paragraph (2) of subdivision (d) of section 86-2.10, adjusted by the RIPAF pursuant to 86-2.10(d). The indirect component shall be further adjusted by an occupancy factor of 1.225 for the first six months of operation.

(iii) The noncomparable component of the rate shall be determined as follows:

(a) For an existing facility that opens a discrete unit for the care of patients under the long-term inpatient rehabilitation program for TBI patients, the noncomparable component of the rate shall be equal to the noncomparable component of the existing residential health care facility's rate computed pursuant to subdivision (f) of section 86-2.10 plus approved budgeted costs for personnel required by the Department to operate a TBI unit that would be reported in the functional cost centers identified in subdivision (f) of section 86-2.10.

(b) For a new facility without a residential health care facility rate computed pursuant to section 86-2.10, the noncomparable component of the rate shall be determined in accordance with paragraph (3) of this subdivision.

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(iv) Rates established pursuant to this paragraph shall also include an adjustment pursuant to section 86-2.10(u) of this Subpart.

~~{(iv) The provisions of this paragraph will expire on December 31, 1994.}~~

(7) Long-term ventilator dependent residents. A facility which is approved to operate discrete units for the care of long-term ventilator dependent patients as established pursuant to ~~section 415.38 of this Title~~ Appendix 2 of this State Plan shall have separate and distinct payment rates established pursuant to this subdivision as follows:

(i) For the first three months of operation, the direct component shall be equivalent to the statewide mean direct case mix neutral cost per day established pursuant to section 86-2.10(c)(3)(iii) of this Subpart increased by a factor of 2.89 and adjusted by the RDIPAF pursuant to section 86-2.10 of this Subpart. The direct component shall be further increased by an occupancy factor of 1.225 for the first six months of operation. The facility shall perform an assessment of all residents, pursuant to section 86-2.30 of this Subpart, at the beginning of the fourth month of operation and at the beginning of each third month for the period set forth in paragraph 1 of this subdivision. Effective on the first day of the month of each assessment period, the direct component of the rate shall be adjusted pursuant to this Subpart based on the facility's case

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mix. The case mix index which is used to establish the facility specific mean direct price per day for each patient classification group pursuant to paragraph (4) of subdivision (c) of section 86-2.10 for long-term ventilator dependent residents shall be increased by an increment of 1.15.

(ii) The direct component of the rate shall be equivalent to the mean indirect price developed pursuant to section 86-2.10(d) for the applicable peer group established for high intensity case mix identified in paragraph (2) of subdivision (d) of section 86-2.10, adjusted by the RIPAF pursuant to section 86-2.10(d). The indirect component shall be further adjusted by an occupancy factor of 1.225 for the first six months of operation.

(iii) The noncomparable component of the rate shall be determined as follows:

(a) For an exiting facility that is approved to operate discrete units for the care of long-term care ventilator residents, the noncomparable component of the rate shall be equal to the noncomparable component of the existing residential health care facility's rate computed pursuant to subdivision (f) of section 86-2.10 plus approved budgeted costs as identified in clauses (c) and (d) of this subparagraph plus approved budgeted costs for personnel required by the Department to operate a ventilator-dependent unit that would be reported in the functional cost centers identified in subdivision (f) of section 86-2.10.

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(b) For a new facility without a residential health care rate computed pursuant to section 86-2.10 of this Subpart, the noncomparable component of the rate shall be determined in accordance with paragraph (3) of this subdivision and include approved budgeted costs identified in clauses (c) and (d) of this subparagraph.

(c) The approved budgeted costs for the central service supply functional cost center as listed in section 86-2.10(c)(1) of this Subpart shall be considered a noncomparable cost reimbursed pursuant to section 86-2.10(f) of this Subpart.

(d) The approved budgeted costs for prescription drugs, specifically required by generally accepted standards of professional practice for long-term ventilator dependent residents, that are administered at a frequency and volume exceeding those of prescription drugs included in the direct component of the rate pursuant to subdivision (c) of this section shall be considered a noncomparable cost pursuant to ~~subdivision (f) of this~~ section 86-2.10(f) of this Subpart.

(iv) Rates established pursuant to this paragraph shall also include an adjustment pursuant to 86-2.10(u) of this Subpart.

~~{(v) The provisions of this paragraph will expire on December 31, 1994.}~~

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(8) Specialized programs for residents requiring behavioral interventions. A facility which is approved to operate discrete units specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions as established by the Department shall have separate and distinct payment rates established pursuant to this subdivision as follows:

(i) For the first three months of operation, the direct component shall be equivalent to the statewide mean direct case mix neutral cost per day established pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of section 86-2.10 of this Subpart increased by a factor of 2.65 and adjusted by the RDIPAF pursuant to section 86-2.10. The direct component shall be further increased by an occupancy factor of 1.225 for the first six months of operation. The facility shall perform an assessment of all residents, pursuant to section 86-2.30 of this Subpart, at the beginning of the fourth month of operation and at the beginning of each third month for the period set forth in paragraph 1 of this subdivision. Effective on the first day of the month of each assessment period, the direct component of the rate shall be adjusted pursuant to section (c) of this Subpart based on the facility's case mix. The case mix index which is used to establish the facility specific mean direct price per day for each patient classification group pursuant to

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paragraph (4) of subdivision (c) of section 86-2.10 for residents requiring behavioral interventions shall be increased by an increment of 1.40.

(ii) The indirect component of the rate shall be equivalent to the mean indirect price developed pursuant to section 86-2.10 for the applicable peer group established for high intensity case mix identified in paragraph (2) of subdivision (d) of section 86-2.10, adjusted by the RIIPAF pursuant to section 86-2.10(d). The indirect component shall be further adjusted by an occupancy factor of 1.225 for the first six months of operation.

(iii) The noncomparable component of the rate shall be determined as follows:

(a) For an existing facility that is approved to operate discrete units specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, the noncomparable component of the rate shall be equal to the noncomparable component of the existing residential health care facility's rate computed pursuant to subdivision (f) of section 96-2.10 plus required approved budgeted costs for personnel that would be reported in the functional cost centers identified in subdivision (f) of section 86-2.10 of this Subpart.

(b) For a new facility without a residential health care rate computed pursuant to section 86-2.10, the noncomparable component of the rate shall be determined in accordance with paragraph (3) of this subdivision.

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(iv) Rates established pursuant to this paragraph shall also include an adjustment pursuant to section 86-2.10(u).

~~[(v) The provisions of this paragraph will expire on  
December 3, 1994.]~~

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86-2.16 Less expensive alternatives. Reimbursement for the cost of providing services may be the lesser of the actual costs incurred or those costs which could reasonably be anticipated if such services had been provided by the operation of joint central service or use of facilities or services which could have served effective alternatives or substitutes for the whole or any part of such service.

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*Effective Date*

JUL. 29 1987

JAN. 1 1988

86-2.17 Allowable costs. (a) To be considered as allowable in determining reimbursement rates, costs shall be properly chargeable to necessary patient care. Except as otherwise provided in this Subpart, or in accordance with specific determination by the commissioner, allowable costs shall be determined by the application of the principles of reimbursement developed for determining payments under title XVIII of the Federal Social Security Act (Medicare) program.

(b) Allowable cost shall include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a residential health care facility.

(c) Allowable costs may not include amounts in excess of reasonable or maximum title XVIII of the Federal Social Security Act (Medicare) costs or in excess of customary charges to the general public. For purposes of this determination, customary charges to the general public shall equal an average of the applicable charges weighted by patient days. This provision shall not apply to services furnished by public providers free of charge or at a nominal fee.

(d) Allowable costs shall not include expenses or portions of expenses reported by individual residential health care facilities which are determined by the commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item.

(e) Any general ceilings applied by the commissioner, as to allowable costs in the computation of reimbursement rates, shall be published in a hospital memorandum or other appropriate manner.

JUL 11 1994

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Supersedes TN 86-4 Effective Date OCT 1- 1990

(f) Allowable costs shall not include costs not properly related to patient care or treatment which principally afford diversion, entertainment or amusement to owners, operators or employees of residential health care facilities.

(g) Allowable costs shall not include any interest charged related to rate determination or penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty.

(h) Allowable costs shall not include the director or indirect costs of advertising, public relations or promotion except in those instances where the advertising is specifically related to the operation of the residential health care facility and not for the purpose of attracting patients.

(i) Allowable costs shall not include costs of contributions or other payments to political parties, candidates or organizations.

(j) Allowable costs shall include only that portion of the dues paid to any professional association which has been demonstrated, to the satisfaction of the commissioner, to be allocable to expenditures other than for public relations, advertising or political contributions. Any such costs shall also be subject to any cost ceilings that may be promulgated by the commissioner.

(k) Allowable costs shall not include any element of costs as determined by the commissioner to have been created by the sale of a residential health care facility.

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(l) Allowable costs shall not include the interest paid to a lender related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained.

(m) Allowable costs shall be reduced by income earned for Medicare Part B eligible services to the extent that Medicaid has paid for these services.

(n) Allowable costs shall include any fee assessed by the Commissioner on a residential health care facility, for the purpose of providing revenue for the account established pursuant to Chapter 1021 of the Laws of 1981. The reimbursement rate for a facility shall reflect the cost of the annual fee prior to collection of the fee through the rate of reimbursement.

(o) For services provided on and after January 1, 2006, allowable costs shall not include an amount for prescription drugs for residents eligible for both Medicaid and for Part D of Title XVIII of the Social Security Act (Medicare) contingent upon implementation of such provision of the Federal Social Security Care Act in this State.

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86-2.18 Recoveries of expense. (a) Operating costs shall be reduced by the costs of services and activities which are not properly chargeable to patient care. In the event that the State Commissioner of Health determines that it is not practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs of these services and activities. Examples of activities and services covered by this provision include:

(1) Drugs and supplies sold to other than employees for use outside the residential health care facility;

(2) telephone and telegraph services for which a charge is made;

(3) discount on purchases;

(4) living quarters rented to persons other than employees;

(5) meals provided to special nurses or patients' guests;

(6) operation of parking facilities for community convenience;

(7) lease of office and other space of concessionaires providing services not related to residential health care facility service; and

(8) tuitions and other payments for educational service, room and board and other services not directly related to residential health care facility service.

(b) Operating costs shall be reduced by the actual revenue received from services and activities which are provided to employees at less than cost, as a form of fringe benefit. Examples of activities and services covered by this provision include:

(1) drugs and supplies sold or provided to employees;

(2) living quarters rented or provided to employees; and

(3) meals sold or provided to employees.

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86-2.19 Depreciation for voluntary and public residential health care facilities. (a) Reported depreciation based on approved historical cost of buildings, fixed equipment and capital improvements thereto is recognized as a proper element of cost for voluntary and public residential health care facilities. Useful lives shall be the higher of the reported useful life or those useful lives from the most recent edition of Estimated Useful Lives of Depreciable Hospital Assets, American Hospital Association.

(b) In the computation of rates effective for voluntary residential health care facilities, depreciation shall be included on a straight line method of plant and nonmovable equipment. Depreciation shall be funded unless the Commissioner of Health shall have determined, upon application by the residential health care facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only for capital expenditures with approval as required for the amortization of capital indebtedness. Funding for plant and fixed equipment shall mean that the transfer of monies to the funded accounts shall occur by the end of the fiscal period in which the depreciation is recorded. Board-designated funds and the accrual of liabilities to the funded depreciation accounts (due to/from accounts) shall not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts to be considered as valid funding transactions unless expanded for the purpose for which it was funded.

(c) In the computation of rates for public residential health care facilities, depreciation is to be included on a straight line method on plant and nonmovable equipment.

(d) Residential health care facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law (defined as "facilities" for purposes of this subdivision only) shall conform to the requirements of this Subpart.

(1) In lieu

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of depreciation and interest, on the loan-financed portion of the facilities the State Commissioner of Health shall allow debt service on the mortgage loan as set forth in the mortgage prepayment schedule computed by the Medical Care Facilities Finance Agency, together with such required fixed charges, sinking funds and reserves as may be determined by the Commissioner as necessary to assure repayment of the mortgage indebtedness. Such mortgage repayment schedule may allow for the accelerated repayment of the soft costs, including, but not limited to, mortgage and bond insurance costs, start-up operating costs, underwriter discounts, government agency fees and investment contract fees, included in the approved total project cost.

(2) Effective January 1, 1995 for facilities in an initial period of operation, facilities which have approved discrete units serving specialty populations as defined in paragraphs (5), (6), (7) and (8) of section 86-2.15(b) of this Subpart, which serve AIDS residents, long term ventilator dependent residents, residents requiring behavioral interventions in specialized programs or traumatic brain injured residents who receive long term inpatient rehabilitation, respectively, shall be reimbursed for certain capital expenditures requiring a cash outlay as follows:

(i) Debt service amortization and interest, property insurance and SONYMA annual fees shall be divided by an estimate of patient days in the calculation of the capital component of the specialty population unit rate that is promulgated for the initial period of operation.

(a) An estimate of patient days shall be determined by the department based on a reasonable projection of utilization during the initial period of operation. The reasonable projection of utilization shall be based on prior initial utilization of similarly situated facilities, and information that may have been submitted to the department by the facility as to the anticipated demand for the service.

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(b) Initial period of operation is defined as the period commencing on the initial effective date on which the facility is certified by the department to begin operation of the discrete unit(s) identified in paragraph (2) of this subdivision, and ending on the last day of the twelfth month of continuous operation or the beginning date of the initial cost report filed in accordance with subdivision (e) of section 86-2.2 of this Subpart, whichever is shorter.

(ii) The capital component of the facility's rate for the initial period of operation shall be subject to audit for utilization based on actual patient days in the initial period of operation. Such capital component of the rate shall be retrospectively or prospectively adjusted based on such audit.

(e) In the computation of rates for voluntary residential health care facilities which are rented for proprietary interests, the provisions of section 86-2.21 of this Subpart shall apply, except where the realty was previously owned by the voluntary residential health care facility or where the proprietary interest has representation on the board of directors of the voluntary residential health care facility.

(f) (1) In the event that a residential health care facility is sold or leased or is the subject of any other realty transaction, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realty transaction has not occurred.

(2) A lease with a related organization described in subdivisions (a) or (d) of section 86-2.26 of this subpart shall be deemed to be a non-arms length lease.

(3) Any capital expenditures associated with non-arms length leases shall be approved and certified to if required under the RHCF Certificate of Need process. In the computation of reimbursement for non-arms length leases, the capital cost shall be included in allowable costs only to the extent that it does not exceed the amount which the facility would

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have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. Accelerated depreciation on these assets may not be included in allowable costs under any circumstances.

~~{(4) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment, the incurred rental specified in the agreement is includable in allowable costs if the following conditions are met:~~

~~(i) the rental charges are reasonable based on consideration of rental charges of comparable equipment and market conditions in the area; the type, expected life, condition and value of the equipment rented and other provisions of the rental agreements;~~

~~(ii) adequate alternate equipment which would serve the purpose are not or were not available at lower cost; and~~

~~(iii) the leasing was based on economic and technical considerations.~~

~~(iv) If all these conditions were not met, the rental charge cannot exceed the amount which the provider would have included in reimbursable costs had it retained legal title to the equipment, such as interest, taxes, depreciation, insurance, and maintenance costs.~~

~~(v) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving land, the incurred rental cost for land shall not be includable in allowable costs.~~

(g)(1) The provisions of subdivision (a) of this section may be waived for certain qualifying facilities. In order to be considered a qualifying facility, all of the following conditions must be met:

(i) A sale or transfer between nonrelated parties must take place

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(ii) The purchaser must assume the seller's remaining mortgage repayment schedule at the associated fixed rate of interest.

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(iii) The difference between the unpaid principal balance of the seller's mortgage (first mortgage) and the Medicaid-allowable transfer price must be generated either from second mortgage proceeds or contributed equity capital or both.

(iv) The annual amount of allowable interest expense incurred as described in section 86-2.20 of this Subpart under terms of the first and second mortgage, plus the annual principal debt amortization, exclusive of that portion attributable to the acquisition of land must be less than that which would otherwise be reimbursed pursuant to subdivision (a) of this section and section 86-2.20 of this Subpart if no assumption of the existing first mortgage were made. (This comparison hereinafter referred to as the comparative analysis test.)

(v) For purposes of this subdivision, the loan-financed portion of the Medicaid-allowable transfer price shall be held constant and the comparative analysis test shall be applied to each year of the effective term of the first and second mortgages. Equity capital will be considered as first applying to the acquisition of the land, then to the acquisition of the building. In instances where more than one facility is involved in the transaction, the facilities may be combined for purposes of the comparative analysis test.

(2) Qualifying facilities shall be reimbursed principal debt amortization, interest and return on equity in the following manner:

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(i) Principal debt amortization. In each year, during the effective term of the mortgage, the capital cost component of the rate shall include a payment factor sufficient to reimburse the principal debt amortization component of the allowable portion of the mortgage, with the exception of that portion of the indebtedness which is attributable to the acquisition of the land.

(ii) Interest. The capital cost component shall include a payment factor sufficient to reimburse interest associated with the allowable portion of the mortgage at a rate which the commissioner finds to be reasonable and is in accordance with the provisions of section 86-2.20 of this Subpart.

(iii) Return of equity. The equity portion of the Medicaid-allowable transfer price, except for that portion which is attributable to the acquisition of the land, shall be reimbursed in equal annual amounts beginning in the first year following the expiration of the term of the mortgages over the remaining useful facility life.

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[86-2.20] Interest for all residential health care facilities.

- (a) Necessary interest on both current and capital indebtedness is an allowable cost for all residential health care facilities.
- (b) To be considered as an allowable cost, debt-generating interest shall be incurred to satisfy a financial need, and interest expense shall be at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained. Financial need for capital indebtedness relating to a specific project shall exist when all available restricted funds designated for capital acquisition of that type have been considered for equity purposes.
- (c) (1) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, trustee malpractice insurance funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor-restricted fund or funded depreciation is an allowable expense. Investment income shall be defined as the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss is not allowable.
- (2) For rate years beginning prior to January 1, 1994, investment income reported for the fiscal year ending December 31, 1983, (or for a subsequent fiscal year if that subsequent year's report is being used by the department to establish the basic rate pursuant to section 86-2.10 of this Subpart) shall reduce the interest expense allowed for reimbursement as follows:
- (i) For all residential health care facilities, investment income shall first reduce the interest expense allowed each year for operational cost reimbursement; and
  - (ii) the amount of any remaining investment income, after application of subparagraph (i), shall reduce the interest expense reimbursed each year as capital cost for residential health care facilities; and

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(d) interest on current indebtedness shall be treated and reported as an operating, administrative expense. Effective April 1, 2006 and thereafter, rates of payment shall not include a payment factor for interest on current indebtedness if the cost report utilized to determine such payment factor also shows a withdrawal of equity, a transfer of assets, or a positive net income.

(e) interest on capital indebtedness, as defined in paragraph 86-2.21(a)(1) of this Subpart, except as provided for in section 86-2.2(c) of this Subpart for rate years beginning January 1, 1986 and thereafter, is an allowable cost if the debt generating the interest is approved by the Commissioner, incurred for authorized purposes, and the principal of the debt does not exceed either the approval of the Commissioner or the cost of the

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- (iii) the amount of any remaining investment income after application of subparagraph (ii), shall not be considered in the computation of the rate.

(3) For rate years beginning on or after January 1, 1994, investment income reported for the same year used to compute capital cost reimbursement for a facility's rate shall reduce the interest expense allowed for reimbursement, as provided in sub-paragraph (c)(2)(i)-(iii) of this section.

(d)(1) Interest on current indebtedness shall be treated and reported as an operating, administrative expense for rate years beginning prior to January 1, 1994. For rate years beginning on or after January 1, 1994, interest on current indebtedness, reported for the same cost report period used to compute capital cost reimbursement for a facility's rate, shall be reported as an administrative expense and reimbursed as a nontrendable expense. Effective April 1, 2006 and thereafter, rates of payment shall not include a payment factor for interest on current indebtedness if the cost report utilized to determine such payment factor also shows a withdrawal of equity, a transfer of assets, or a positive net income.

(2) (a) Approval by the Commissioner shall be required for reimbursement of interest expense on current indebtedness incurred on or after January 1, 1994 when such interest expense exceeds the threshold established for that calendar year. The threshold for each calendar year shall be equal to the prime lending rate as published in the first issue of the Wall Street Journal for the calendar year plus 200 basis points (200 points equals 2%) on a loan principal of \$270,000 for facilities with 120 or less beds or \$270,000 plus an additional \$2,250 for each bed over 120 for facilities with more than 120 beds. Approval shall be granted in accordance with the standards set forth in subdivision (b) of this section. Prior approval shall not be required.

\* For example, for a home with 100 beds (i.e., less than 120) the threshold would be prime rate + 2% applied to \$270,000. For a home having 150 beds, the threshold will be the prime rate + 2% applied to \$270,000 + \$2,250 (30 beds) or \$337,500.

(b) New facilities without adequate cost experience whose rates are calculated pursuant to section 86-2.15 of this Subpart shall be exempt from the requirements in subparagraph (a) until January 1<sup>st</sup> of the first calendar year used as the basis for

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computing capital cost reimbursement and for which a cost report is filed subsequent to the cost report described in section 86-2.2(e) of this Subpart. This exemption shall not apply to operating facilities that open new discrete units providing services reimbursed in accordance with the provisions of paragraphs (5), (6) and/or (7) of section 86-2.15(b) of this Subpart or other similar discrete units providing care to residents with special needs that receive a separate and distinct payment rate under section 86-2.15 of this Subpart.

(c) The interest expense threshold for facilities operated by receivers or new operators who are required to file a cost report for the first twelve-month period of operation pursuant to section 86-2.10(k) of this Subpart shall be established for that cost report period in accordance with subparagraph (a) of this paragraph, using the prime lending rate in effect on January 1<sup>st</sup> of the year in which the cost report period begins.

(e) Interest on capital indebtedness, as defined in paragraph 86-2.2(a)(1) of this Subpart, except as provided for in section 86-2.20(c) of this Subpart for rate years beginning January 1, 1986 and thereafter, is an allowable cost if the debt generating the interest is approved by the commissioner, incurred for authorized purposes, and the principal of the debt does not exceed either the approval of the commissioner or the cost of the authorized purposes. Interest related to refinancing indebtedness shall be considered an allowable cost only to the extent that it is payable with respect to an amount equal to the unpaid principal of the indebtedness [than] being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of the refinanced indebtedness will be allowable on acceptable demonstration [of] to the Commissioner of Health that such refinancing will result in a debt service savings over the life of the indebtedness.

(f) Where a public finance authority has established a mortgage rate of interest such that sufficient case flows exist to retire the mortgage prior to the stated maturity, the amount of the mortgage to be forgiven, at the time of such forgiveness, shall be capitalized as a deferred asset and amortized over the remaining mortgage life, as a reduction to the facility's capital expense.

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86.2.21 Capital Cost reimbursement for proprietary residential health care facilities. (a) *Definitions*. As used in this section, the following terms shall be defined as follows:

(1) *Capital indebtedness*. The term *capital indebtedness* shall mean all debt obligations of a facility that are:

(i) evidenced by a mortgage note or bond and secured by a mortgage on the land, building or nonmovable equipment of a facility or evidenced by a note incurred in accordance with subparagraph (ii) of this paragraph;

(ii) incurred for the purpose of financing the acquisition, construction or renovation of land, building or nonmovable equipment (hereinafter called the "authorized purpose"); and

(iii) found by the commissioner to be reasonable, necessary and in the public interest with respect to the facility in accordance with standards set forth in section 86-2.21(e)(3)(ii) of this Subpart. Refinancing of capital indebtedness shall be recognized only to the extent of the then unpaid balance of the debt being refinanced.

(2) *Commissioner*. The term *commissioner* shall mean the Commissioner of Health of the State of New York.

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(3) *Department.* The term *department* shall mean the Department of Health of the State of New York.

(4) *Equity.* The term *equity* shall mean all cash or other assets, net of liabilities, invested by a facility or its operator in land, building and nonmovable equipment, and found by the commissioner to be reasonable, necessary and in the public interest with respect to the facility. *Equity* shall not include any change in the book value of a facility resulting from reevaluation of assets or from the amortization of capital indebtedness resulting from payments made pursuant to subdivision (e), paragraph (3) of this section.

(5) *Facility.* The term *facility* shall mean a proprietary residential health care facility, as the term *residential health care facility* is defined in article 28 of the Public Health Law and in regulations of the department.

(6) *Initial allowed facility cost.* The term *initial allowed facility cost* shall mean the portion of certified costs approved by the commissioner or, in the case of facilities granted operating certificates prior to April 15, 1973, the costs of the facility as verified by audit to the satisfaction of the commissioner or, in the case of facilities not able to comply with either of the foregoing standards, costs imputed

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pursuant to subdivision (g) of this section, in or prior to the first year of useful facility life attributable to the acquisition of land and the construction, acquisition or renovation of building and nonmovable equipment. The commissioner shall disregard any costs relating to prior transactions involving the facility which he finds were not bona fide or the terms of which are found to be other than fair and reasonable.

(7) Useful facility life. The term useful facility life shall mean a period of 40 years measured from the calendar year in which a facility commences operations as determined by the commissioner.

(8) Rate of return. The term rate of return shall mean the annual rate of return on equity invested, [as said rate is determined by the United States Department of Health, Education and Welfare as an element of reasonable cost for purposes of payments to or reimbursement of proprietary providers under title XVIII of the Federal Social Security Act.] and said rate for a rate year shall be equal to the yield on thirty year United States Treasury bonds in effect on the second Wednesday of September of the year prior to the rate year.

(9) Capital improvement. The term capital improvement shall mean any addition to, replacement of, or improvement of a capital item of plant or nonmovable equipment approved by the commissioner as reasonable, necessary and in the public interest.

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(10) *Capital improvement cost.* The term *capital improvement cost* shall mean the actual expenditure or portion thereof attributable to a capital improvement approved by the commissioner as reasonable, necessary and in the public interest.

(11) *Hospital-based residential health care facility.*  
The term *hospital-based residential health care facility* shall mean a facility holding a certificate of operation as a residential health care facility which is wholly owned by a hospital as that term is defined in Subpart 86-1 of this Title, and is physically located in a building or buildings, part of which building or buildings are also used for provision of acute care hospital services.

(12) *Effective term.* The term *effective term* shall mean the number of years and months required, pursuant to the term of the note or mortgage, to fully amortize the principal of debt, predicated upon the regular principal payments required by the mortgage or note, but determined without regard to any provision for making the balance all due and payable at a given date or upon a stated event, and without regard to any provision for acceleration of the debt or any original or subsequent agreement for the suspension or moratorium of principal payments.

(b) Subject to subdivision (f) of this section, the reimbursement rate of every facility certified by the commissioner

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and approved by the State Director of the Budget pursuant to article 28 of the Public Health Law shall, in each year of useful facility life, include a capital cost component determined in accordance with the provisions of subdivision (c), (d) or (e) of this section applicable to the facility in such year.

(c)(1) The provisions of subdivision (e) of this section shall not apply for the term prescribed by paragraph (3) of this subdivision to any facility which, as of the effective date of this section, is located in and operated from leased space pursuant to a lease:

(i) which was entered into and approved for reimbursement prior to March 10, 1975; and

(ii) which the commissioner finds to be bona fide, valid and noncancelable; and

(iii) the payments, or a portion thereof, made pursuant to such lease are found by the commissioner to have been the proper basis for reimbursement of capital cost paid to such facility pursuant to article 28 of the Public Health Law prior to March 10, 1975.

(2) The capital cost component of a facility within the provisions of paragraph (1) of this subdivision shall, for the term prescribed by paragraph (3) of this subdivision, consist of

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a payment factor sufficient to reimburse the facility for the total payments required under its lease to the extent approved by the commissioner pursuant to paragraph (1) of this subdivision, and subject to the historical limitations set by the commissioner.

(3) Capital cost reimbursement for leased facilities shall be made pursuant to this subdivision for the balance of the lease term (computed without regard to any future extension or option to renew authorized by the lease) remaining as of the effective date of this subdivision. Upon the expiration of such balance of the lease term provided in an approved lease (as said lease so provides as of August 1, 1977) or such earlier expiration date as may be agreed to by the parties to an approved lease, capital cost reimbursement shall be made pursuant to subdivision (e) of this section notwithstanding any extension or renewal of such lease or the execution of a new lease by or on behalf of the facility, provided, however, that the commissioner may, in his discretion, continue capital cost reimbursement for such leased facilities pursuant to this subdivision, at a rental amount approved by the commissioner prior to such extension or renewal, and not pursuant to subdivision (e), upon his finding that there is a public need

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for such facility at the time and place and under the circumstances proposed and that the continued operation of such facility would be jeopardized by a limitation of reimbursement pursuant to subdivision (e).

(4) A lease with a related organization described in subdivisions (a) or (d) of section 86-2.26 of this subpart shall be deemed to be a non-arms length lease.

(5) Any capital expenditures associated with non-arms length leases shall be approved and certified to, if required, under the hospital certificate of need process. In the computation of reimbursement for non-arms length leases, the capital cost shall be included in allowable costs only to the extent that it does not exceed the amount which the facility would have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. Accelerated depreciation on these assets may not be included in allowable costs under any circumstances.

~~(6) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment, the incurred rental specified in the agreement shall be included in allowable costs if the following conditions are met:~~

~~(i) the rental charges are reasonable based on consideration of rental charges of comparable equipment and market conditions in the area;~~

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~~the type, expected life, condition and value of the equipment rented and other provisions of the rental agreements;~~

~~(ii) adequate alternate equipment which would serve the purpose are not or were not available at lower cost; and~~

~~(iii) the leasing was based on economic and technical considerations.~~

~~(iv) If all these conditions were not met, the rental charge cannot exceed the amount which the provider would have included in reimbursable costs had he retained legal title to the equipment, such as interest, taxes, depreciation, insurance and maintenance costs.~~

~~(v) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving land, the incurred rental cost for land shall not be included in allowable costs.~~

(d) The provisions of subdivision (e) of this section shall not apply to hospital-based residential health care facilities. Such facilities will be reimbursed pursuant to capital cost regulations in Subpart 86-1 of this part.

(e)(1) Subject to the provisions of subdivisions (c), (d) and (f) of this section, the capital cost component for every facility shall consist of the payment factors provided in this subdivision that, in any year of useful facility life, are applicable to the facility.

(2) Interest. The capital cost component shall, in each year of useful facility life, include a payment for factor sufficient to reimburse, at a rate which the commissioner finds to be reasonable under the circumstances prevailing at the time of the placing of the capital indebtedness, interest on capital indebtedness.

(3) Amortization. (i) Subject to the limitations of paragraph (5) of this subdivision, the capital cost component shall, in each year of useful facility.

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life, include a payment factor sufficient to reimburse the amortization component of capital indebtedness pursuant to the terms of the mortgage note or bond.

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(ii) The capital indebtedness of a facility, to the extent that the original principal of such debt does not exceed the initial allowed facility cost of the facility shall be recognized as follows:

(a) For capital indebtedness with an effective term of 10 years or less, amortization expense will be recognized for the purpose of reimbursement only, if the schedule of debt amortization is within the limitation set forth in section 86-2.21(e)(5) of this Subpart for each of the years of debt amortization.

(b) For capital indebtedness with an effective term in excess of 10 years, amortization expense will be recognized for the purpose of reimbursement upon a determination by the commissioner that the following standards are met:

(1) the debt is incurred for authorized purposes;

(2) the interest rate is reasonable for the time and place in which the capital indebtedness is committed, and for the type of indebtedness associated with the interest rate;

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(3) the amortization schedule is reasonable (amortization must be required in each year of the mortgage in accordance with the established financial practices);

(4) the effective term is consistent with customary commercial practices in the geographic area of the facility; and

(5) the effective term is in accordance with efficient production of services.

c) For capital indebtedness other than first mortgages, the amortization expense will be recognized for the purpose of reimbursement upon a determination by the commissioner that the debt, complies with the standards set forth in section 86-2.21(e)(3)(ii)(b) of this Subpart, and the following additional standards:

(1) they must be incurred for the purpose of financing either an approved purchase or construction of a facility; and

(2) the effective term of financing for a capital improvement is reasonable when compared to the estimated useful life of the improvement.

(d) Capital indebtedness for any unauthorized purpose will not be recognized for any reimbursement purpose.

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(4) Return of equity. Subject to the limitations of paragraph (5) of this subdivision, the capital cost component shall include a payment factor sufficient to return equity. A facility shall be eligible for the return of equity commencing in the first year following the department's determination, among other factors, that the facility has the ability to meet current capital indebtedness (including principal and interest) over the balance of useful facility life. This shall mean that within the confines of the regulations expressed in this Subpart, capital reimbursement will be sufficient to provide for the remaining amortization of capital indebtedness. The commissioner's determination shall also take into account such factors as the age, size, location and condition of the facility, and the financial condition of the facility.

(5) Limitation. (i) Annual reimbursement payments for capital cost under paragraphs (3) and (4) of this subdivision shall not at any time result in a cumulative average payment in excess of three and three one-hundredths percent of initial allowed facility cost. For years prior to 1981, actual amortization or depreciation paid by Medicaid will be used in the computation of the limitation. For years prior to Medicaid or in years when Medicaid payments did not include an expense equivalent of depreciation or amortization, a three and three one-hundredths percent payment will be imputed.

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(ii) This limitation may be waived by the commissioner where a facility applies to the commissioner for approval to finance an existing mortgage because its recognized amortization expense exceeds the amount of allowable reimbursement for amortization of principal and interest expense (including credit from prior amortization reimbursement). In those instances where the commissioner determines that it would be more expensive to reimburse the debt service that would be incurred if the facility refinanced the remaining principal, than it would be to continue to reimburse the debt service on the existing mortgage, the commissioner may reimburse up to the actual debt service incurred by the facility under the existing mortgage, plus return on equity in accordance with the provisions of paragraph (6) of this subdivision.

(6) Return on equity. The capital cost component for every facility shall include a payment factor sufficient to pay an annual rate of return on average equity, as such average annual equity shall be determined by the commissioner in each year of useful facility life.

(7) Residual reimbursement. After the expiration of useful facility life, the commissioner may approve a payment

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factor for any facility for which he determines that continued capital cost reimbursement is appropriate; provided, however, that such payment factor shall not exceed one half of the capital cost reimbursement received by such facility in the final year of useful facility life.

(8) Capital improvement cost reimbursement. (i) The capital improvement cost shall be reimbursed by adjusting the initial allowed facility cost, capital indebtedness, equity determinations and limitations as stated in paragraph (5) of this subdivision, to include the capital improvement cost.

(ii) Adjustments in accordance with subparagraph (i) of this paragraph shall be made in the following manner:

(a) if the cost of an improvement is \$100,000 or more, and certificate of need approval has been granted by the commissioner, then component useful life for the improvement will be permitted. Such component useful life will be equivalent to the estimated asset life in accordance with the *Medicare Provider Reimbursement Manual* or the remaining useful life of the facility, whichever is less. Where a capital improvement adjusts the expected useful life of the facility beyond the remaining portion of the original useful facility life, the limitation set

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forth in section 86-2.21(e)(5) of this Subpart, will be increased to allow for the reimbursement of the amortization component of the debt obtained to finance the improvement.

(b) If the cost of an improvement is less than \$100,000, then the cost will be reimbursed over the remaining portion of the expected useful life. In such instances the reimbursement will commence with either the reporting of such costs on an annual certified cost report or, upon submission of a cost report, certified by an independent public accountant, whichever is submitted first. In either event, the reporting of such costs must be accompanied by a sworn statement by the administrator or the chief fiscal officer of the facility to the effect that the improvements made are not part of a number of planned related projects which, in the aggregate, total \$100,000 or more.

(c) If the cost of an improvement is less than \$100,000 and:

(1) is undertaken as the result of an emergency situation;

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provide exceptions to subdivision (c) or (e) of this section in circumstances where he finds that application of the provisions of either subdivision would result in (i) excessive reimbursement to the facility, or (ii) severe economic hardship to the facility not caused by circumstances reasonably under the control of the facility. In determining severe economic hardship, the commissioner shall consider such factors as debt service required on capital indebtedness, prior withdrawal of assets from the facility, and the financial condition of the facility in general. In such cases where the commissioner makes a finding of severe economic hardship, the capital cost component of the rate shall not exceed the debt service on capital indebtedness.

(2) The commissioner may revise the capital cost component of the reimbursement rate applicable to any facility which he determines is based upon previous error, deceit or any other misrepresentation or misstatement by the facility.

(3) The capital cost component shall not be affected by any sale, lease or transfer occurring after March 10, 1975.

(g) In lieu of determining initial allowed facility cost pursuant to subdivision (a) of this section, the commissioner may estimate the original fair and reasonable cost of the facility with due regard for the fair and reasonable cost of facilities of comparable age, size, location and condition, and impute an initial allowed facility cost to:

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(1) every facility for which records on the historical cost or book value of land, building or nonmovable equipment are not available or not verifiable to the satisfaction of the commissioner;

(2) every leased facility which, as of the effective date of this section, is not eligible for reimbursement pursuant to subdivision (c) of this section;

(3) every facility which, after the effective date of this section, ceases to be eligible for reimbursement pursuant to subdivision (c) of this section and becomes eligible for reimbursement pursuant to subdivision (e) of this section; or

(4) every facility whose construction was completed prior to the calendar year in which this section becomes effective and whose initial facility year occurs in or after the calendar year in which this section becomes effective.

(h) In the event that a facility fails to submit information necessary for the implementation of this section, after notification pursuant to subdivision (f) of section 86-2.2 of this Subpart, the capital cost component of the rate shall consist of interest, if reported, and amortization not in excess of the lesser of the amortization payment required under capital indebtedness, or 2 1/2 percent of initial allowed facility cost.

(i)(1) The limitation provision of paragraph (e)(5) of this section may be waived for certain qualifying facilities. In order to be considered a qualifying transaction, all of the following conditions must be met:

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(i) A sale or transfer between nonrelated parties must take place.

(ii) The purchaser must assume the seller's remaining mortgage repayment schedule at the associated fixed rate of interest.

(iii) The difference between the unpaid principal balance of the seller's mortgage (first mortgage) and the Medicaid-allowable transfer price must be generated either from second mortgage proceeds or contributed equity capital or both.

(iv) The annual amount of allowable interest expense incurred as described in this section, under the terms of the first and second mortgage, plus the annual principal debt amortization must be less than that which would otherwise be reimbursed pursuant to this section, if no assumption of the existing first mortgage were made. (This comparison is hereinafter referred to as the comparative analysis test.) For purposes of this subdivision, the loan-financed portion of the Medicaid-allowable transfer price shall be held constant and the comparative analysis test shall be applied to each year of the effective term of the first and second mortgages. In instances where more than one facility is involved in the transaction, the facilities may be combined for purposes of the comparative analysis test.

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(2) Qualifying facilities shall be reimbursed principal debt amortization, interest and return of equity in the following manner:

(i) Principal debt amortization. In each year, during the effective term of the mortgage, the capital cost component of the rate shall include a payment factor sufficient to reimburse the principal debt amortization component of the allowable portion of the mortgage.

(ii) Interest. The capital cost component shall include a payment factor sufficient to reimburse interest associated with the allowable portion of the mortgage as defined by paragraph (e)(2) of this section.

(iii) Return of equity. The equity portion of the Medicaid-allowable transfer price shall be reimbursed in equal annual amounts beginning in the first year following the expiration of the term of the mortgages over the remaining useful facility life.

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(i)(1) The Commissioner shall timely develop and implement a standardized process for assessing the feasibility of capital mortgage refinancing, including a standard formula for determining the net cost benefit of refinancing, inclusive of all transaction and closing costs. On or before September 1, 2003, each residential health care facility established under Section 2808 of the Public Health Law and certified as a provider pursuant to Title XIX of the federal Social Security Act (Medicaid), except for those facilities established under the Nursing Home Companies Law or the Hospital Loan Construction Law, shall review its existing capital debt structure using the standard formula to evaluate whether or not a material cost benefit could be derived by refinancing its capital mortgage or mortgages, and shall forward the results of such review to the Commissioner. The Commissioner may request and such facility shall submit descriptions of existing mortgage arrangements and debt service reserve funds as needed to implement paragraph (2) of this subdivision. Facilities established under the Nursing Home Companies Law or the Hospital Loan Construction Law shall submit to the Dormitory Authority, the Housing Finance Agency and/or the State of New York Mortgage Agency such information as is required by such agency to evaluate potential refinancing of such capital mortgages.

(2) The Commissioner shall review each facility's submission and make a written determination as to whether or not the facility should refinance its capital mortgage or mortgages, and if so, for what amount, within sixty days of the date of the facility's submission based on the following parameters:

(a) the mortgage refinancing must result in a present value cost benefit that "materially exceeds", as such term is defined by the Commissioner, the amount of all transaction and closing costs associated with the refinancing, including any pre-payment penalties associated with the current mortgage or mortgages. The Commissioner shall do such calculations in a manner consistent with comparable calculations in the State Finance Law;

(b) mortgages may be refinanced for a term greater than the remaining term of the existing debt within certain limits, if doing so would result in the present value cost benefit specified in subparagraph (a) of this paragraph;

(c) mortgages may be refinanced utilizing variable rate mortgage loans, if doing so would result in the present value cost benefit specified in subparagraph (a) of this paragraph. In such cases, for purposes of determining the reimbursable capital interest expense included in the capital cost component of rates of payment determined pursuant to this section, the average interest rate over the life of the refinanced mortgage shall not exceed the interest rate in effect on the previous mortgage debt immediately prior to the refinancing;

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(d) not-for-profit and governmental residential health care facilities may utilize taxable mortgage loans to refinance their existing debts, if doing so would result in the present value cost benefit specified in subparagraph (a) of this paragraph;

(e) moneys contained in facility debt service reserve funds may be considered in the evaluation of amounts necessary to be refinanced, but only to the extent such moneys total more than the debt service reserves needed to establish the successor capital mortgage financing;

(f) in no event shall funded depreciation accounts, or building funds accumulated through donor-restricted contributions or unrestricted contributions, gifts, bequests or legacies, be considered in the evaluation of amounts necessary to be refinanced; and

(g) notwithstanding any inconsistent provision of law or regulation to the contrary, the principal amount, including all transaction and closing costs and any pre-payment penalties associated with the previous mortgage or mortgages, that is thereby deemed necessary to be refinanced by the Commissioner, as approved by the Public Authorities Control Board and the United States Department of Housing and Urban Development where appropriate, shall be considered the final, approved mortgage amount for capital cost reimbursement under the relevant provisions of this section.

(3) Notwithstanding any inconsistent provision of law or regulation to the contrary, the capital cost component of rates of payment for services provided for the period beginning October 1, 2003 through March 31, 2004 for residential health care facilities that have been identified by the Commissioner as refinancing candidates pursuant to paragraph (2) of this subdivision shall reflect capital interest costs equivalent to the lower of the prevailing market borrowing rates available on or about July 1, 2003, for refinancing capital mortgages for their remaining term plus two hundred basis points, or the existing rate being paid by the facility on its capital mortgage or mortgages as of that date. The Commissioner shall determine, in consultation with mortgage financing experts, the prevailing market borrowing rates available

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to not-for-profit and governmental residential health care facilities to refinance capital mortgages on a tax-exempt fixed rate basis, and to proprietary residential health care facilities to refinance capital mortgages on a taxable fixed rate basis, for this purpose. Exceptions to this policy shall be provided by the Commissioner to each such facility that demonstrates, prior to December 1, 2003, or thirty days after receipt of the Commissioner's written determination specified in paragraph (2) of this subdivision, whichever occurs later, that:

(a) it has initiated or completed the process of refinancing the mortgage or mortgages in question, in which case the capital cost component of rates of payment shall be timely revised to reflect capital interest costs associated with a refinanced mortgage that conforms to the standards in paragraph (2) of this subdivision. For this purpose, a facility that has applied for approval by the Commissioner, the State Hospital Review and Planning Council and/or Public Health Council to refinance its existing mortgage debt as part of a larger project involving facility replacement, expansion, renovation or change of ownership is considered to have initiated the process of refinancing; or

(b) it can not refinance its capital mortgage or mortgages to achieve the relevant present value cost benefit specified in subparagraphs (a) and (b) of paragraph (2) of this subdivision due to a "lock out" or similar provision in its current mortgage agreement that prevents re-financing; due to some other type of genuine refinancing obstacle, such as an inability of the facility to obtain credit approval from a lender or mortgage insurer, or due to an intervening change in credit market conditions or other relevant circumstances, in which case the capital cost component of rates of payment shall continue to reflect capital interest costs associated with the existing mortgage or mortgages, together with reasonable costs incurred in connections with the facility's attempt to refinance its existing mortgage debt.

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- (4) Each residential health care facility established under the New York State Nursing Home Companies Law and designated as an acquired immune deficiency syndrome (AIDS) facility or having a discrete AIDS unit approved by the Commissioner of Health shall refinance its capital mortgage on or before August 1, 2004 or 120 days immediately after the effective date of the authorizing legislation, whichever is later, and shall forward the results of such refinancing to the Commissioner of Health; provided however, no such residential health care facility shall be required to refinance its capital mortgage if the Department of Health, in consultation with the Dormitory Authority of the State of New York, determines that such refinancing could not be accomplished on an economic basis or is otherwise not feasible. Notwithstanding any inconsistent provision of law or regulation to the contrary, in the event that any such residential health care facility does not refinance its capital mortgage and the Department of Health has not made a determination that a refinancing was not economic or feasible, then the capital cost component of rates of payment determined pursuant to Article 28 of the New York State Public Health Law for such facilities beginning August 1, 2004 or 120 days immediately after the effective date of the authorizing legislation, whichever is later, shall reflect the capital interest cost equivalent to the lower of: (i) the prevailing market borrowing rates available for refinancing capital mortgages for their remaining term on or about August 1, 2004 or 120 days immediately after the effective date of the authorizing legislation, whichever is later; or (ii) the existing rate being paid by the facility on its capital mortgage or mortgages as of such date. The Commissioner of Health shall determine, in consultation with the Dormitory Authority of the State of New York, the prevailing market borrowing rates available to residential health care facilities to refinance capital mortgages.

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86-2.22 Movable equipment. (a) Necessary and reasonable expenses related to movable equipment (depreciation computed on a straight-line method or accelerated under a double declining balance [on] or sum-of-the-years-digits method, interest on indebtedness, lease, etc.) are considered allowable costs for residential health care facilities subject to such ceilings as may be established and promulgated by the Commissioner of Health.

(b) An arms length lease purchase agreement with a nonrelated lessor involving equipment entered into on or after October 23, 1992 which meets any one of the four following conditions, establishes the lease as a virtual purchase.

(1) The lease transfers title of the equipment to the lessee during the lease term.

(2) The lease contains a bargain purchase option.

(3) The lease term is at least 75 percent of the useful life of the equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the equipment.

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(4) The present value of the minimum lease payments (payments to be made during the lease term including bargain purchase option, guaranteed residual value and penalties for failure to renew) equals at least 90 percent of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the equipment. Present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case the interest rate implicit in the lease is used.

(c) If a lease is established as a virtual purchase under subdivision (b) of this section, the rental charge is includable in capital-related costs as the lesser of the annual rent or the annual costs of ownership which shall be limited to depreciation and interest. When the cost of ownership becomes less than the annual rent, the rental charge shall be includable in capital-related costs. The aggregate rental or lease costs included in capital-related costs may not exceed the costs of ownership that would have been included in capital-related costs over the useful life of the asset had the provider received legal title to the asset.

(d) If a facility enters into a sale and leaseback agreement involving equipment on or after October 23, 1992, the amounts to be included in capital-related costs are the lesser of the annual rent or the annual costs of ownership. When the cost of ownership becomes less than the annual rent, the rental charge shall be includable in capital-related costs. The aggregate rental or lease costs included in capital-related costs may not exceed the costs of ownership which shall be limited to depreciation and interest that would have been included in capital-related costs over the useful life of the asset had the provider retained legal title to the asset.

86-2.23 Research. (a) All research costs shall be excluded from allowable costs in computing reimbursement rate.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understanding, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.

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86.2.24 Educational activities. The costs of educational activities, less tuition and supporting grants, shall be included in the calculation of the basic rate, provided such activities are directly related to patient care services.

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86-2.25 Compensation of operators and relatives of operators. .

(a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable cost. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a nonrelated employee, as determined by the State Commissioner of Health. Compensation shall not be included in the rate computation for any services which the operator or relative of the operator is not authorized to perform under New York State law or regulation.

(b) Any amount reported as compensation for services rendered by an operator or relative of an operator shall not be allowed in excess of the maximum allowance for full-time services in carrying out his primary function.

(c) For purposes of subdivision (a) of this section, in determining a reasonable level of compensation for operators or relatives of operators the commissioner may consider the quality of care provided to patients by the facility during the year in question.

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86-2.26 COST OF RELATED ORGANIZATIONS. (a) A RELATED ORGANIZATION shall be defined as any entity which the residential health care facility is in control of or is controlled by, either directly or indirectly, or an organization or institution whose actions or policies the facility has the power, directly or indirectly, to significantly influence or direct, or a special purpose organization, or where an association or material interest exists in an entity which supplies goods and/or services to the residential health care facility, or any entity which is controlled directly or indirectly by the immediate family of the operator. Immediate family shall include each parent, child, spouse, brother, sister, first cousin, aunt and uncle, whether such relationship arises by reason of birth, marriage or adoption.

(b) The costs of goods and/or services furnished to a residential health care facility by a related organization are includable in the computation of the basic rate at the lower of the cost to the related organization, or the market price of comparable goods and/or services available in the residential health care facility's region within the course of normal business operations.

(c) If the residential health care facility has incurred any costs in connection with a related organization, the final payment rate shall include the costs of such goods and/or services.

(d) A special purpose organization shall be defined as an organization which is established to conduct certain of the provider's patient-care-related or non-patient-care-related activities. The special purpose organization shall be considered to be related if:

(1) the facility controls the special purpose organization through contracts or other legal documents that allow direct authority over the

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(2) the facility is, for all practical purposes, the sole beneficiary of the special organization's activities. The facility shall be considered the special purpose organization's sole beneficiary if one or more of the three following circumstances exist:

(i) a special purpose organization has solicited funds in the name of and with the expressed or implied approval of the facility, and substantially all the funds solicited by the organization were intended by the contributor or were otherwise required to be transferred to the facility or used at its discretion or direction;

(ii) the facility has transferred some of its resources to a special purpose organization, substantially all of whose resources are held for the benefit of the facility; or

(iii) the facility has assigned certain of its functions (such as the operation of a dormitory) to a special purpose organization that is operating primarily for the benefit of the facility.

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86-2.27 Termination of service. The Division of Health Care Financing in the Department of Health shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notifications shall include a statement indicating the date of the deletion or withholding of such service and the cost impact on the residential health care facility of such action. Any overpayments by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 86-2.7 of this Subpart.

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86-2.28 Return on investment. (a) [In] For rate year 1993, in computing the allowable cost of a proprietary residential health care facility, there will be included, after subtracting for current and noncurrent time deposits and equivalents, investments and construction in progress, a reasonable return on average equity capital [excluding capital invested in land, plant, fixed equipment and capital improvements thereto.] invested for necessary and proper operation for patient care activities of residential health care facility and related organizations, as defined in section 86-2.26(a) of this Subpart. For purposes of this section, average equity capital shall mean the difference between total assets less total liabilities averaged over the applicable cost report period, including assets and liabilities attributable to land, plant, fixed equipment and capital improvements thereto. It shall also include the average equity capital of related organizations proportionate with the percentage of a related organization's business with the residential health care facility, as calculated in the annual report forms filed in accordance with section 86-2.2 of this Subpart.

(b) The allowable average equity capital shall be further adjusted by subtracting the equity, as that term is defined in section 86-2.21(a)(4) of this Subpart, upon which a return is calculated pursuant to section 86-2.21(e)(6) of this Subpart. The return on investment for rate year January 1, 1993 shall be computed on the basis of allowable fiscal and statistical data submitted by the facility for the fiscal year ended December 31, 1991, or other applicable cost report period used to determine the capital component of the 1993 rate, in accordance with section 86-2.21 of this Subpart. The return on investment for subsequent

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rate year shall be based upon the annual cost report used by the department to determine the capital component of the rate in accordance with section 86-2.21 of this Subpart. The percentage to be used in computing the return on investment shall be [that percentage determined annually by the commissioner and shall be] equal to the twenty-six week United States Treasury Bill rate in effect on the second Wednesday of September of the year prior to the rate year.

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86-2.29 Payments to receivers. - Section deleted from State Plan.

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86-2.30 Residential Health Care Facilities Patient Assessment for Certified Rates.

(a) For the purpose of determining reimbursement rates effective January 1, 1986, and thereafter, for governmental payments each residential health care facility shall, on an annual basis or more often as determined by the department, pursuant to this subpart, assess all patients to determine case mix intensity using the patient review criteria and standards promulgated and published by the department (Patient Review Instrument [PRI] and Instructions: Patient Review Instrument) and specified in appendix 7 infra.

(b)(1) The patient review form (PRI) shall be submitted according to a written schedule determined by the department. Such written schedule shall be established by the Commissioner of Health with notice to residential health care facilities. Extension of the time for filing may be granted upon application received prior to the due date of the Patient Review Forms and only in circumstances where the residential health care facilities establishes, by documentary evidence, that the patient review forms cannot be submitted by the due date for reasons beyond the control of the facility.

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(2) Rate schedules shall not be certified by the Commissioner of Health unless residential health care facilities are in full compliance with the requirements of this section. Compliance with the assessment requirements of this section, shall include, but not be limited to, the timely filing of properly certified patient review forms (PRI) which are complete and accurate. Failure of a residential health care facility to file the patient review form (PRI) pursuant to the written schedule established pursuant to this subdivision, shall subject the residential health care facility to a rate reduction set forth in section 86-2.2 of this Subpart.

(c) The operator of a residential health care facility shall ensure:

(1) that the patient review form (PRI) is completed for all patients of the facility pursuant to subdivision (a) of this section.

(2) that the patient review form (PRI) is completed by a registered professional nurse who is qualified by experience and demonstrated competency in long term care and who has successfully completed a training program in patient case mix assessment approved by the department to

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train individuals in the completion of the patient review form (PRI) for the purposes of establishing a facility's case mix financial reimbursement; and

((3) notwithstanding paragraph (2) of this subdivision, an operator of a free-standing health-related facility may substitute no more than two licensed practical nurses who are qualified by experience and demonstrated competence in long-term care and who have successfully completed a training program in patient case mix assessment for the purposes of establishing a facility's case mix financial reimbursement for meeting the required number of assessors pursuant to subdivision (d) of this section. Such substitution may occur only in the instance that a free-standing health-related facility does not employ a sufficient number of staff registered nurses to meet the required number of assessors pursuant to subdivision (d) of this section; and

(4)] (3) that the patient review form (PRI) is certified by the operator and the nurse assessor responsible for completion of the patient review form (PRI). (The form of the certification required shall be as prescribed in the report form provided by the department.)

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(d) In order to maximize reliability and accuracy, a limited number of personnel for each residential health care facility may be responsible for completion of the patient review form (PRI) during each assessment period. The maximum number of personnel which may be responsible for residential health care facility is as follows:

<u>Bed Size of Facility</u>	<u>Number of Responsible Assessors</u>
<u>Under 100</u>	<u>Two</u>
<u>101 to 200</u>	<u>Three</u>
<u>201 to 300</u>	<u>Four</u>
<u>301 to 400</u>	<u>Five</u>
<u>401+</u>	<u>Five plus one additional assessor for each additional 100 beds or part thereof.</u>

(e)(1) The Department shall monitor and review each residential health care facility's performance and its patient assessment function as described in this section through the following activities which may include but shall not be limited to:

(i) Analysis of patient case mix profiles and statistical data;

(ii) Review of information provided by the residential health care facility; and

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(iii) On-site inspections.

(2) The purpose of the department's monitoring and review shall be to determine whether the residential health care facility is complying with the assessment requirements contained in this section.

(3) The patient review form (PRI) and any underlying books, records, and/or documentation which formed the basis for the completion of such form shall be subject to review by the department.

(4) The department shall acknowledge, in writing, receipt of the residential health care facilities patient review forms (PRI). In the event that any information or data that the facility has submitted is inaccurate or incorrect, the facility shall correct such information or data in the following manner:

(i) The facility shall submit to the department, within five days of receipt of the department's written acknowledgement provided for in this paragraph, such corrections on a form which meets the same certification requirements as the document being corrected. Once receipt of corrected data is acknowledged in writing by the department, a residential health care facility may not correct or amend the patient review for (PRI) or submit any additional information for the assessment period.

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(5) The department, in order to ensure accuracy of the patient review form (PRI), may also conduct timely on-site observations and/or interviews of patients/residents and review of their medical records. When an additional on-site review is performed by the department as a result of controverted items found during the initial on-site review, the facility shall be afforded an on-site conference prior to the conclusion of such additional on-site review. Upon completion of a department on-site review pursuant to this subdivision, the department, in order to ensure accuracy of the patient review form (PRI), shall correct, where necessary, a residential health care facility's assessment of its patient case mix intensity. The department's on-site determination shall be considered final for purposes of assessing the residential health care facility's case mix intensity for that assessment period and notwithstanding section 2.14 of this Subpart, the residential health care facility may not correct or amend the patient form (PRI) or submit any additional information after department reviewers have concluded the on-site review. The residential health care facility shall be notified in writing regarding the department determination of any controverted items.

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(f) (1) If the department determines pursuant to this section, that a residential health care facility is not performing its case mix intensity assessment function in a timely and/or accurate manner, as required by subdivision (b) of this section, the department shall, in writing:

(i) Notify the residential health care facility; and

(ii) Require the residential health care facility to perform its patient case-mix assessment function through written agreement with a person or entity approved by the department for the completion of the patient review form (PRI) for the purpose of establishing a residential health care facilities case mix reimbursement.

(iii) Any patient case mix assessment performed pursuant to subparagraph (ii) of the paragraph shall also be subject to department monitoring and review pursuant to this section.

(2) The department shall determine that a residential health care facility is not performing its case-mix intensity assessment function in an accurate manner where there exists inaccuracies in its case-mix assessment which results in a statistically significant modification of the residential health care facility's reimbursement.

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(3) The cost of written agreements required by paragraph (1) of this subdivision shall not be considered an allowable cost for determining reimbursement rates pursuant to this Subpart.

(4) Certification. Operators of residential health care facilities completing the department's patient review form (PRI) through written agreement with a department approved non-residential health care facility person or entity shall have such form certified by such person or entity in lieu of a facility registered professional nurse as required by paragraph (2) of subdivision (c) of this section.

(q) Reconsiderations.

(1) Any residential health care facility after one year from the date it has been notified in writing by the department that it must enter into a written agreement pursuant to paragraph (1) of subdivision (f) of this section, may request, in writing, that the department rescind its withdrawal of the residential health care facility's patient case mix assessment function.

(2) The department shall not rescind its withdrawal of a residential health care facility's patient case mix assessment function unless the residential health care

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facility satisfies the department that the residential health care facility has the capability to comply with the requirements of the department's patient casemix assessment process which shall include the capability to accurately complete the patient review form (PRI).

(3) The department shall give written notice of its decision and shall, if negative, give a statement of the reasons for its refusal to rescind its withdrawal of the residential health care facility's patient case mix assessment function.

(4) Any residential health care facility after six months from the date it receives a written department decision pursuant to paragraph (3) of this subdivision, may again request in writing that the department rescind its withdrawal of the residential health care facility's patient case mix assessment function.

[(h) The provisions of this section shall expire on April 30, 1989.]

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(j) Residential health care facilities [with 80 or more beds] shall submit the data contained in the PRI using an electronic medium including but not limited to magnetic computer tape, floppy disk or an electronic telecommunication system consistent with the technical specifications established by the department.

[(i)] (1) The electronically produced data shall be accompanied by a certification statement executed by the operator or a person authorized to sign on the operator's behalf in a format provided or approved by the department.

[(ii)] (2) Facilities [required or those electing to submit PRI data in this format] shall have an additional ten days from the time specified pursuant to subdivision (b) of this section to file the required information.

[(iii)] (3) Adjustments to certified rates made pursuant to section 86-2.11 of this Subpart shall be certified by the Commissioner of Health within 90 days from the date upon which a facility's rate was last certified pursuant to this Subpart or within 90 days from the latest scheduled PRI submission date pursuant to section 86-2.11 of this Subpart, whichever is later. Such ninety day time frames shall not apply in any instance where a facility has been notified that its submitted PRI data is inaccurate or incorrect pursuant to paragraph (e)(4) of [subdivision (e) of section 86-2.30 of] this [Subpart] section until such data has been corrected to the satisfaction of the commissioner, or if an additional on-site review has been deemed necessary pursuant to paragraph (e)(5) of [subdivision (e) of section 86-2.30 of] this [Subpart] section.

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2.31 Recalibration. (a) For rate periods commencing on or after January 1, 1987, notwithstanding any other provisions of this Subpart, the Direct Component of facility rates, determined in accordance with sections 86-2.10 and 86-2.11 of this Subpart, shall be reduced by 3.035 percent to reflect a recalibration adjustment based on the change in the aggregate statewide case mix index attributable to factors other than changes in patient population or condition.

(b) The reduction in the Direct Component of facility rates as defined in subdivision (a) of this section shall be implemented on or about July 1, 1987 and shall be applied retroactive to January 1, 1987.

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(b) For rate years 1992 and thereafter, notwithstanding any other provision of this Subpart and subject to the provisions of paragraph (1) of this subdivision and subdivision (c) of this section, payment rates shall be adjusted in accordance with this subdivision to reflect a percentage recalibration adjustment based on the change in each facility's case mix which has been determined by the department to be due to factors other than changes in patient population or condition. Such payment rate adjustments shall be implemented utilizing the direct component of facility rates for such rate years determined in accordance with sections 86-2.10 and 86-2.11 of this Subpart.

(1) The percentage recalibration adjustment provided for in this subdivision shall not be less than 0% nor greater than one hundred fifty percent of the statewide weighted average percentage recalibration adjustment obtained by utilizing the facility-specific percentage recalibration adjustments as determined pursuant to this subdivision.

(2) The percentage recalibration adjustment shall be calculated as follows for each facility:

(i) A statewide distribution of patients in each patient classification group shall be determined by utilizing the patient data for the assessment of all patients obtained in the patient assessment period March 1, 1985 through September 30, 1985 (the 1985 period) conducted pursuant to section 86-2.30 of this Subpart.

(ii) The statewide distribution of patients in each patient classification group shall be further segregated by the following length of stay (LOS) groups:

- (a) less than or equal to 90 days
- (b) greater than 90 days but less than or equal to 1 year
- (c) greater than 1 year but less than or equal to 2 years
- (d) greater than 2 years but less than or equal to 3 years

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(e) greater than 3 years but less than or equal to 4 years

(f) greater than 4 years but less than or equal to 5 years

(g) greater than 5 years

(iii) A statewide average initial case mix index for each LOS group for the 1985 period shall be calculated by multiplying the initial distribution of patients in each patient classification group within each LOS group times the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the total number of patients in all patient classification groups within each LOS group.

(iv) For each facility, a 1985 distribution of patients in each patient classification group and a 1985 distribution of patients by the LOS groups specified in subparagraph (ii) of this paragraph shall be determined by utilizing the patient data for the assessment of all patients obtained in the 1985 period, conducted pursuant to section 86-2.30 of this Subpart. In the event a facility commenced operations after the patient assessment period, March 1, 1985 through September 30, 1985 (the 1985 period) but prior to January 1, 1988, or if the facility has the lesser of ten cases or twenty percent of its patients in the distributions as determined in this subparagraph for the 1985 period, or if the facility had undergone the appointment of a receiver or the establishment of a new operator

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subsequent to the 1985 period but prior to January 1, 1988 and had filed a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which was used in the calculation of the payment rate, the distribution of patients to be used for the purposes of this subparagraph shall be that distribution pertaining to the earliest full patient assessment period conducted pursuant to section 86-2.30 of this Subpart subsequent to the 1985 period or subsequent to the effective date of the appointment of a receiver or the change in operator (the "substituted 1985 period"), and such distribution shall be deemed the facility's "substituted 1985 distribution" of patients for the calculations in subparagraphs (vi) and (vii) of this paragraph. For purposes of this subparagraph, the only patients to be included in the distributions shall be patients that have been identified by the department as also having been included in the patient assessment period July 1, 1988 through December 31, 1988.

(v) For each facility, a 1988 distribution of patients in each patient classification group and a 1988 distribution of patients by the LOS groups specified in subparagraph (ii) of this paragraph shall be determined by utilizing the patient data obtained in the patient assessment period July 1, 1988 through December 31, 1988. For purposes of this subparagraph, the only patients to be included in the distributions shall be patients that were admitted to the facility in which they are presently residing before October 1, 1985 and have been identified by the department as also having been included in the patient assessments during the 1985 period. In the event a facility commenced operations after the

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patient assessment period, March 1, 1985 through September 30, 1985 (the 1985 period) but prior to January 1, 1988 or if the facility had the lesser of ten cases or twenty percent of its patients in the distributions for the 1985 period as determined pursuant to subparagraph (iv) of this paragraph, or if the facility had undergone the appointment of a receiver or the establishment of a new operator subsequent to the 1985 period but prior to January 1, 1988 and had filed a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which was used in the calculation of the payment rate, the facility's substituted 1985 period, as defined in subparagraph (iv) of this paragraph, shall be used in lieu of the 1985 period for the purposes of this subparagraph, and the only patients to be included shall be patients that were admitted to the facility in which they are presently residing before the end date of the facility's substituted 1985 period and have been identified by the department as also having been included in the patient assessments during the substituted 1985 period.

(vi) A percentage increase in case mix attributable to LOS shall, for each facility, be determined as follows:

(a) A 1985 aggregate case mix index shall be determined by multiplying the facility's 1985 distribution of patients, or a substituted 1985 distribution of patients where applicable, within each LOS group, determined pursuant to subparagraph (iv) of this paragraph by the statewide average initial case mix index for each LOS group for the 1985 period, as determined pursuant to subparagraph (iii) of this paragraph, and dividing the sum of the results by the facility's total number of patients in all LOS groups, as determined pursuant to subparagraph (iv) of this paragraph.

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(b) A 1988 LOS adjusted case mix index shall be determined by multiplying the facility's 1988 distribution of patient within each LOS group determined pursuant to subparagraph (v) of this paragraph by the statewide average initial case mix index for each LOS group for the 1985 period, as determined pursuant to subparagraph (iii) of this paragraph, and dividing the sum of the results by the facility's total number of patients in all LOS groups, as determined pursuant to subparagraph (v) of this paragraph.

(c) The 1985 aggregate case mix index shall be subtracted from the 1988 LOS adjusted case mix index and the result divided by the 1985 aggregate case mix index to arrive at the percentage increase in case mix attributable to LOS.

(vii) An actual percentage increase in case mix shall, for each facility, be determined as follows:

(a) A 1985 actual case mix index shall be determined by multiplying the facility's 1985 distribution of patients, or a substituted 1985 distribution of patients where applicable, in each patient classification group as determined pursuant to subparagraph (iv) of this paragraph, by the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the facility's total number of patients in all patient classification groups, as determined pursuant to subparagraph (iv) of this paragraph.

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(b) A 1988 actual case mix index shall be determined by multiplying the facility's 1988 distribution of patients in each patient classification group, as determined pursuant to subparagraph (v) of this paragraph, by the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the facility's total number of patients in all patient classification groups, as determined pursuant to subparagraph (v) of this paragraph.

(c) The 1985 actual case mix index shall be subtracted from the 1988 actual case mix index and the result divided by the 1985 actual case mix index to arrive at an actual percentage increase in case mix.

(viii) Except as provided in subparagraph (ix) of this paragraph, a percentage recalibration adjustment shall be determined by annualizing the result obtained by subtracting the percentage increase in case mix attributable to LOS determined pursuant to subparagraph (vi) of this paragraph from the actual percentage increase in case mix determined pursuant to subparagraph (vii) of this paragraph.

(ix) If a facility undergoes the appointment of a receiver or the establishment of a new operator on or after January 1, 1992 and files a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which is used in the calculation of a revised payment rate, or for new facilities who receive an initial operating certificate on or after January 1, 1992, the percentage recalibration adjustment provided for in this subdivision shall be 0% for such revised payment rate or for such new facilities.

\*The three-year effect of improved coding was annualized by taking the cube root of the three year accumulation factor.

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JAN 01 1992

(3) The operating portion of each residential health care facility's rate of payment, as defined pursuant to paragraph (7) of subdivision (a) of Section 86-2.10 of this Subpart, shall be reduced by a per diem recalibration adjustment which shall be determined as follows:

(i) The percentage recalibration adjustment identified in subparagraph (viii) of paragraph (2) of this subdivision shall be applied to the direct component of the rate determined in accordance with Sections 86-2.10 and 86-2.11 of this Subpart, to arrive at each facility's per diem recalibration adjustment in 1983 base year dollars.

(ii) Each facility's per diem recalibration adjustment in 1983 base year dollars shall then be trended to the rate year by the applicable roll factor as defined in paragraph (8) of subdivision (a) of Section 86-2.10 of this Subpart.

(c) For a residential health care facility receiving a percentage recalibration adjustment greater than zero percent, as determined in subdivision (b) of this section, the percentage recalibration adjustment may be modified when conditions set forth in section 86-2.31(c)(1) are met. Additionally, a facility shall submit a modification request as an appeal application within the time limit set forth in section 86-2.13(a) of this Subpart.

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(ii) A facility shall document that the percentage change in the facility's reported case mix index (CMI) from the annual rate period 1985 through 1988, such percentage reduced by the percentage recalibration adjustment as determined by subdivision (b) of this section, is at least ten percent.\* The percentage change in the facility's reported CMI, for purposes of this subparagraph, shall utilize the CMI calculated from the facility's patient data obtained during the patient assessment period, March 1, 1985 through September 30, 1985, to the patient assessment period July 1, 1988 through December 31, 1988, conducted pursuant to section 86-2.30 of this Subpart, and shall be calculated by subtracting from the reported 1988 CMI, the reported 1985 CMI and the result divided by the reported 1985 CMI.

(iii) (a) Except as provided in clause (b) of this subparagraph, a facility shall document that the percentage change in direct care cost over trend from the annual rate period 1985 through 1988, as defined by those cost centers listed in subdivision (c) of section 86-2.10 of this Subpart, is at least ten percent. The percentage change in direct care cost over trend for purposes of this subparagraph shall be calculated by subtracting from the 1988 annual reported direct care cost, the 1985 annual reported direct care cost trended to 1988 by the applicable trend factors promulgated by the department for 1986, 1987 and 1988, and the result divided by the trended 1985 direct care cost. The annual reported direct care costs for 1985 and 1988, for purposes of this subparagraph, shall be those which the facility has submitted using the result of the single step-down method of cost allocation.\*\*

\*This means that the increase in reported case mix from 1985 to 1988, after subtracting out the recalibration adjustment for the facility, must be at least ten percent for the facility to qualify to possibly get a reduction in its recalibration adjustment.

\*\*This refers to the allocation of the accumulated facility costs as reported via the RHCf cost reports into other cost centers that utilize their services. The purpose of the step-down process is to finally consolidate reimbursable costs into the four components of the RHCf reimbursement rate for rate setting purposes. For example, costs reported under patient-specific services such as transportation, nursing administration and therapies, among others, are finally allocated to the costs contained in the direct portion of the rate.

TN 92-07 Approval Date AUG 21 1986

(b) In the event a facility's facility-specific cost based direct price per day exceeds the facility-specific ceiling direct price per day, as determined pursuant to section 86-2.10(c)(4) of this Subpart, for the annual rate period 1988, such excess percentage shall be used to determine a credit to be added to the facility's percentage change in direct care cost over trend as determined in clause (a) of this subparagraph for the purposes of meeting the required percentage change in direct care cost over trend identified in clause (a) of this subparagraph. The amount of the credit shall be equal to such excess percentage if the facility documents that its percentage change in indirect care cost over trend from the annual rate period 1985 through 1988, as defined by those cost centers listed in subdivision (d) of section 86-2.10 of this Subpart, does not exceed its percentage change in direct care cost over trend for this period, as determined in clause (a) of this subparagraph, and if the facility cannot so document, the credit identified in this clause shall be reduced (but not be less than 0%) by the extent to which the percentage change in indirect care cost over trend exceeds the percentage change in direct care cost over trend. The percentage change in indirect care cost over trend for purposes of this subparagraph shall be calculated by subtracting from the 1988 annual reported indirect care cost, the 1985 annual reported indirect care cost trended to 1988 by the applicable trend factors promulgated by the department for 1986, 1987 and 1988, and the result divided by the trended 1985 indirect care cost. The annual reported indirect care costs for 1985 and 1988, for purposes of this subparagraph, shall be those which the facility has submitted using the result of the single step-down method of cost allocation.

(iv) Documentation shall be included in an appeal filed by the facility to the department that supports the reasons for the direct care cost increase which shall be based on increases in staffing levels and/or range and/or types of patient services. Increased direct care cost resulting

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solely from an increase in the bed complement of a facility shall not constitute sufficient justification for granting a modification pursuant to this subdivision.

(2) For a facility meeting all conditions specified in paragraph (1) of this subdivision, the modified percentage recalibration adjustment shall be determined as follows.

(i) The modification to the percentage recalibration adjustment shall be determined by annualizing the result obtained by subtracting the percentage change in the facility's reported CMI reduced by the percentage recalibration adjustment, as determined in subparagraph (ii) of paragraph (1) of this subdivision, from the percentage change in direct care cost over trend, as determined in subparagraph (iii) of paragraph (1) of this subdivision.

(ii) The modified percentage recalibration adjustment shall be equal to the result obtained by subtracting the modification to the percentage recalibration adjustment, as determined in subparagraph (i) of this paragraph, from the percentage recalibration adjustment identified in subparagraph (viii) of paragraph (2) of subdivision (b) of this section.

(iii) The modified percentage recalibration adjustment, as determined in subparagraph (ii) of this paragraph, shall not be less than 0%.

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New York  
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**APPLICATION OF 1992 RECALIBRATION APPEAL CRITERIA**

**EXAMPLE**

**ASSUMPTIONS**

1. Reported CMI Change, 1985-1988	24.44%
2. Recalibration % (Annualized)	7.40%
3. Real CMI Change, 1985-1988	17.04% (1-2)
4. Direct Cost-Over-Trend, 1985-1988	8.71%
5. Indirect Cost-Over-Trend, 1985-1988	10.50%
6. % Facility Above Direct Ceiling	20.9%

**APPLICATION OF CRITERIA**

- Real CMI change (17.04%) meets 10% requirement
- Direct Cost-Over-Trend (8.71%) does not meet the 10% requirement.

However, since this facility is above ceiling on direct costs, a credit amount is determined, to be added to the direct cost growth of 8.71%.

**CALCULATION OF CREDIT**

- Excess of indirect Cost-Over-Trend compared to direct cost:  
 $10.50\% - 8.71\% = 1.79\%$
- Credit Amount:  $20.9\% - 1.79\% = 19.11\%$
- Direct Cost-Over-Trend with credit:  
 $8.71\% + 19.11\% = 27.82\%$

**CALCULATION OF MODIFIED RECALIBRATION**

Since the revised value of direct cost growth with the credit (27.82%) exceeds the 10% requirement, facility qualifies for a modification, subject to appropriate documentation showing that direct care cost increases were due to increases in staffing levels or range/types of services.

Modification Value =  $27.82\% - 17.04\% = 10.78\%$   
(Dir. cost) - (real CMI change)  
This is then annualized, giving 3.47%

Modified Recalibration Adjustment =  $7.40\% - 3.47\% = 3.93\%$

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Nursing facilities (NF) shall receive prospective 1994 rate enhancements to their rates of payment, effective November 3, 1994 through December 31, 1994. An amount not to exceed \$111 million shall be distributed to all eligible nursing facilities through 1994 prospective rate enhancements to their rates of payment. Eligible facilities shall be those facilities that sought timely relief for such rate enhancements. Such amount shall be allocated to each eligible NF based upon its reported change in patient case mix as determined by the total number of patients properly assessed and reported by the facility pursuant to 86-2.30, in excess of that reimbursed for the same base period, 1989-1991. The facility's allocated share of the prospective payment enhancement shall be converted to a per diem adjustment by dividing this amount by its volume of Medicaid days for the period November 3, 1994 through December 31, 1994.

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Supersedes TN 91-24 Effective Date Nov.3, 1994

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TN 91-24 Approval Date OCT 29 1992  
Supersedes TN 87-7 Effective Date APR 1 1991

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86-2.33 Dementia Pilot Demonstration Projects. (a) Payment rates shall be adjusted by the addition of a per diem amount as determined by the commissioner pursuant to this section for residential health care facilities participating in pilot demonstration projects for the development of additional knowledge and experience in the area of dementia care and to improve the quality of care and treatment of patients with dementia.

(b) The adjustment to payment rates provided for in this section shall be made for qualifying residential health care facilities (RHCFs) applying for and receiving the approval of the commissioner for participation in such projects. Acceptable uses of such adjustment shall include but shall not be limited to:

- (1) increasing the availability of programs and resources for dementia patients;
- (2) training staff to manage behavior or promote effective care of dementia patients;
- (3) arranging the environment in ways that produce positive outcomes for dementia patients; and/or
- (4) maintaining and promoting autonomy and decision-making on the part of dementia patients.

(c) Individual facilities or groups of facilities may participate in pilot demonstration projects pursuant to this subdivision.

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supercedes  
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MAR 30 1990

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01/01/89

New York  
110(a)(1)

86-2.33  
Attachment 4.19-D  
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**EXPLANATION OF DEMENTIA PILOT PROJECT RATE ADJUSTMENT**

The per diem for dementia care pilot demonstration projects is calculated by dividing the total award for each facility by the duration (i.e., years) of the project to determine the annual expenditure. This annual expenditure is then divided by the annualized Medicaid patient days reported by the facility to arrive at the per diem add-on.

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110(a)(2)

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Effective January 1, 2000, enhancements to the Medicaid reimbursement rates of hospice-operated nursing homes will be provided to enable them to study and analyze several issues pertaining to operations of such a nursing home. This demonstration will provide additional knowledge and experience and will collect information concerning alternative methodologies for reimbursement, delivery of medical services or eligibility of medical assistance in such facilities.

The hospice-operated nursing home will conduct a demonstration to address several patient care related issues including:

1) insuring appropriate placement and use of resources for residents in hospice-operated nursing homes;

2) training staff to promote effective care of terminally ill residents;  
and

3) maintaining and promoting autonomy and decision making on the part of the residents in hospice-operated nursing facilities.

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APR 01 2000

Effective for dates of service beginning on April 1, 2002 and ending on December 31, 2004, Medicaid rates of payment to non-public nursing homes shall be adjusted pursuant to a competitive process to fund projects intended to improve the quality of care for nursing home residents. This competitive process will follow the Request for Proposal procurement process, as mandated by the NYS Office of the State Comptroller.

Such eligible projects may include:

- (a) an increase in direct care staff, either facility wide or targeted at a particular area of care or shift;
- (b) increased training and education of direct care staff, including allowing direct care staff to increase their level of licensure relevant to nursing home care;
- (c) efforts to decrease staff turn-over; and
- (d) other efforts related to the recruitment and retention of direct care staff that will effect the quality of care at such facility.

The evaluation of each submitted proposal will be based on the following criteria:

- (1) proposal demonstrates that the project will improve the quality of care in a cost effective manner;
- (2) proposal provides evidence that the project can be successfully implemented;
- (3) proposal provides evidence that the quality of care will be improved by improving or increasing the training, education and retention of direct care staff;
- (4) proposal provides a detailed budget with a cost effective approach;
- (5) proposal demonstrates financial need; and
- (6) proposal provides a written labor union concurrence from the relevant bargaining agent for the projects where a collective bargaining agreement exists covering occupations in which training is proposed.

A proposal may be rejected if the submitting facility has significant non-compliance in areas that affect resident health and safety.

Submitted proposals will be ranked based on the results of the review and evaluation process. Proposals achieving a predetermined minimum score will receive an initial award determined by multiplying the score, expressed as percentage, by the project amount requested. Available funds will be distributed as follows:

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110(a)(4)

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(04/06)

- (a) If the total amount initially awarded for all nursing homes equals the total funding available, each nursing home will receive its initial award.
- (b) If the total amount initially awarded for all nursing homes exceeds the total funding available, each initial award will be reduced on a proportional basis such that the sum of all final awards does not exceed the total funds available.
- (c) If the total amount initially awarded for all nursing homes is less than the total funding available, each nursing home will receive its initial award. Remaining funds will be distributed proportionally based on each nursing home's initial award to the total of all initial awards.

Nursing homes receiving awards shall submit an annual progress report that describes and evaluates the quality improvements achieved through this project. Significant changes from the approved project or budget may result in a revision to the nursing home's award. Funding may be discontinued if it is determined that the goal of the project is not being met. The Department of Health shall have the right to audit the nursing home's financial records to determine that the funds granted for this project have been used for the specific purposes defined in the approved proposal and shall recoup any funds determined to have been used for purposes other than specified in the approved proposal.

The Department of Health will not issue any new requests for proposals after December 31, 2004, and all awards for subsequent annual periods will be distributed on the same proportional basis as the most recent available distribution. Funds may be utilized for any of uses listed in this Section and the Department of Health shall have the right to audit to determine that the funds have been used accordingly, and recoup any funds determined to have been used otherwise.

Resultant adjustments to Medicaid rates of payment shall not, in aggregate, exceed 62.5 million dollars for the rate period beginning April 1, 2002 and ending December 31, 2002, and for each annual period thereafter beginning January 1, 2003 and ending December 31, 2004, and shall not exceed, in aggregate, 46.875 million dollars for the period July 1, 2005 through December 31, 2005, and [31.25] 78.125 million dollars [on an annualized basis,] for the period January 1, 2006 through [June 30, 2007] December 31, 2006, and 62.5 million dollars for the period January 1, 2007 through June 30, 2007. Award amounts shall be included as a reimbursable

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110(a)(4)(i)**

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(04/06)**

cost add-on to medical assistance fee-for-service rates of payment established pursuant to this section, based on Medicaid utilization data in each facility's annual cost report submitted two years prior to the rate year or projected Medicaid utilization data for those facilities that have not submitted an annual cost report for the period two years prior to the rate year. These adjustments shall not be subject to subsequent adjustment or reconciliation to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

**TN #06-17** \_\_\_\_\_

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**Effective Date** APR -1 2006

Section 86-2.34 Affiliation changes. (a) A hospital based residential health care facility as defined in section 86-2.10(a)(13) of this Subpart whose affiliated hospital closes its acute care beds shall notify the department within 30 days of actual complete closure of such beds. Such residential health care facility shall have its affiliation status changed to freestanding effective as of the date of actual complete closure.

(b) For purposes of establishing the allowable indirect component of the rate pursuant to subdivision (d) of section 86-2.10 of this Subpart, a hospital based residential health care facility whose affiliation changes to freestanding under circumstances described in subdivision (a) of this section may apply to the department at the same time notice of closure is given pursuant to subdivision (a) of this section for a three year phase in of its freestanding affiliation for reimbursement purposes effective the beginning of the next calendar year following actual complete closure of its acute care beds.

(1) For the rate effective January 1 of the calendar year following actual complete closure of the affiliated hospital's acute care beds, the mean indirect price per day determined pursuant to section 86-2.10(d)(4)(i) of this Subpart shall be determined by summing the product of multiplying the mean indirect price per day of the appropriate hospital based peer group by .75 and the product of multiplying the mean indirect price per day of the appropriate freestanding peer group by .25.

(2) For the rate effective January 1 of the second calendar year following actual complete closure of the affiliated hospital's acute care beds, the mean indirect price per day determined pursuant to section 86-2.10(d)(4)(i) of this Subpart shall be determined by summing the product of multiplying the mean indirect price per day of the appropriate hospital based peer group by .50 and the product of multiplying the mean indirect price per day of the appropriate freestanding peer group by .50.

(3) For the rate effective January 1 of the third calendar year following actual complete closure of the affiliated hospital's acute care beds, the mean indirect price per day determined pursuant to section 86-2.10(d)(4)(i) of this Subpart shall be determined by summing the product of multiplying the mean indirect price per day of the appropriate hospital based peer group by .25 and the product of multiplying the mean indirect price per day of the appropriate freestanding peer group by .75.

(c) For purposes of establishing the factor determined pursuant to section 86-2.12(a) of this Subpart, a hospital based residential health care facility whose affiliation changes to freestanding under circumstances described in subdivision (a) of this section and has applied for a three year phase in of the freestanding indirect component pursuant to subdivision (b) of this section shall continue to be classified as hospital based for a period of three calendar years following the actual complete closure of the affiliated hospital's acute care beds.

(d) A hospital based residential health care facility whose affiliation changed to freestanding under the circumstances described in subdivision (a) of this section that fails to notify the department within 30 days from the date of actual complete closure of the acute care beds shall not be eligible for the provisions of subdivision (b) and subdivision (c) of this section.

Such facilities shall be designated freestanding, for rate calculation purposes, pursuant to this Subpart retroactive to the date of actual complete closure of the acute care beds of the affiliated hospital.

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110(d)(1)

Attachment 4.19-D  
(04/08)

**Pay for Performance Incentive**

- (a) The Commissioner shall make rate adjustments, effective May 1, 2008, and thereafter, to certain residential health care facilities who demonstrate to the satisfaction of the Commissioner that they can meet or exceed defined quality measures.
- (b) Initial awards shall be based on a residential health care facility's performance for pressure ulcer quality of care for chronic care residents.
- (c) The Commissioner shall make two sets of awards as follows:

An award shall be made for the best performers for the evaluation period. Best performers are those facilities ranked in the top four percentile of all eligible residential health care facilities according to the four quarters average score for the period January 1, 2007 through December 31, 2007.

An award shall be made to residential health care facilities with the best improvement in pressure ulcer care between a base and evaluation period. Best improvers are those facilities ranked in the top four percentile of all eligible residential health care facilities according to the base and the evaluation periods four quarters average score. The base period score shall be based on the period July 1, 2006 through June 30, 2007; the evaluation score shall be based on the period July 1, 2007 through June 30, 2008. Facilities in the bottom quarter percentile of all eligible residential health care facilities for this evaluation period shall not be eligible for such an award if, even after their improvement in pressure ulcer care, they still remain in the bottom quarter percentile of all eligible residential health care facilities; and

Residential health care facilities that qualify are eligible to receive an award in both categories of awards.

- (d) The evaluation period for the award for best performers shall be January 1, 2007 through December 31, 2007. The base period for the award for best improvement shall be July 1, 2006 through June 30, 2007, which shall be compared to the period July 1, 2007 through June 30, 2008.
- (e) The following factors shall be considered by the Commissioner in making awards pursuant to this section:

The quality measure of pressure ulcer shall be risk adjusted using such patient health factors to include but not be limited to, coma, malnutrition, diseases and conditions related to pressure ulcer, low body mass index, and plegia (paraplegia or hemiplegia);

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**New York  
110(d)(2)**

**Attachment 4.19-D  
(04/08)**

Pressure ulcer rates shall be considered only for chronic care residential health care facility residents;

In order to be eligible to be considered for a rate enhancement, a residential health care facility must have averaged more than one prevented pressure ulcer per quarter of the evaluation period identified in paragraph (d) of this section as calculated by comparing the actual number of residents with a pressure ulcer to the expected number of residents with a pressure ulcer based on the facility's risk adjusted pressure ulcer rate developed pursuant to this subdivision; and

Any residential health care facility receiving a written deficiency for substandard quality of care, as defined in federal regulation 42 C.F.R. §488.301, during the evaluation periods contained in this section shall be excluded from receiving an award under this section.

- (f) Rate adjustments made pursuant to this section for residential health care facilities receiving monetary awards shall be made proportionately based on each eligible facility's percent of Medicaid patient days to the total Medicaid patient days for all eligible facilities. Such days of care are as reported in the latest RHCF-4 cost reports for patients eligible for medical assistance.

Residential health care facilities chosen to receive rate enhancements pursuant to this section shall, prior to the rate enhancement, inform the Commissioner in writing as to their proposed use of the additional monies to further improve quality and care of patients in the residential health care facility.

- (g) A total of \$3,000,000 will be paid as rate adjustments.

TN #08-01

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86-2.36 Scheduled short term care. (a) Residential health care facilities which provide scheduled short term care for residents shall be paid a per diem rate of reimbursement for such services which is the average per diem rate of reimbursement for the facility as established pursuant to this Subpart.

(b) The requirements of sections 86-2.11 and 86-2.30 relating to resident assessments (PRI) and the submission of case mix information to the Department shall not apply to scheduled short term care.

Clarifying Information:

1. Scheduled short term care is care provided to individuals who are determined to need nursing facility care but are being cared for by someone in the community, and who do not participate in a Home and Community Based Waiver program.
2. All federal nursing facility statutory and regulatory requirements, including those related to admission, discharge and transfer, continue to apply to scheduled short term care services.
3. Individuals may receive no more than 30 days of scheduled short term care for a given admission, and no more than a total of 42 days of scheduled short term care during a given year.
4. If an individual receives services in the nursing facility for a time period exceeding the maximum limits specified in (3), the admission will be considered as a normal nursing facility admission for state and federal regulatory purposes, and the reimbursement for such services will be according to the standard state nursing facility rate-setting methodology contained in this Part of the plan.

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New York  
110(E)  
Appendix

Attachment 4.19D  
Part I

Provider Assessments. For purposes of determining rates of payment for residential health care facilities beginning July 1, 1992 for beneficiaries eligible for medical assistance under Title XIX of the federal Social Security Act, a state assessment of 1.2% of residential health care facility gross revenues received during the period April 1, 1992 through March 31, 1994, and as may be extended by statute, shall be a reimbursable cost to be included in calculating rates of payment. The state assessment of 1.2% of RHCF gross revenues shall be in effect from April 1, 1992 through March 31, 1994, and as may be extended by statute. Effective July 1, 1995 through March 31, 1996, and as may be extended by statute, an additional state assessment of 3.8% of facility gross revenues shall be a reimbursable cost to be included in calculating rates of payment.

Effective for the period April 1, 1996 through April 30, 1996, the further additional assessment will be reduced from 3.8% to 1.9% of each facility's cash receipts from all patient care services and other operating income, for a total state assessment of 3.1% of facility gross revenues which shall be a reimbursable cost to be included in calculating rates of payment. Effective on or after May 1, 1996, rates of payment will be adjusted to allow costs associated with a total state assessment of 5.4% of facility gross revenues which shall be a reimbursable cost to be included in calculating rates of payment.

The reimbursable operating costs of facilities for purposes of calculating the reimbursement rates will be increased prospectively, beginning July 1, 1992, to reflect an estimate of the provider cost for the assessment for the period. As soon as practicable after the assessment period, an adjustment will be made to RHCF rates based on a reconciliation of actual assessment payments to estimated payments.<sup>1</sup>

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<sup>1</sup> The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

TN 96-24 Approval Date JUN 06 2001  
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**New York  
110(E)(1)**

**Attachment 4.19-D  
(04/09)**

Effective January 1, 1997, the rates of payment will be adjusted to allow costs associated with a total State assessment of 5% of facility gross revenues which shall be a reimbursable cost to be included in calculating rates of payment. Effective March 1, 1997, the reimbursable assessment will be 3.1%. Effective April 1, 1997, the total reimbursable state assessment to be included in calculating rates of payment will be 4.8%. Effective April 1, 1999 through December 31, 1999, the total reimbursable state assessment of 2.4% of gross revenues as paid by facilities shall be included in calculating rates of payment. Effective April 1, 2002 through March 31, 2003, April 1, 2003 through March 31, 2005, and April 1, 2005 through March 31, [2009] 2011, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for hospital or health-related services, including adult day service, but excluding, effective October 1, 2002, gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), shall be six percent, five percent, and six percent, respectively.

The reimbursable operating costs of facilities for purposes of calculating the reimbursement rates will be increased prospectively, beginning July 1, 1992, to reflect an estimate of the provider cost for the assessment for the period, provided, however, that effective October 1, 2002 the adjustment to rates of payment made pursuant to this paragraph shall be calculated on a per diem basis and based on total reported patient days of care minus reported days attributable to Title XVIII of the federal social security act (Medicare) units of service. As soon as practicable after the assessment period, an adjustment will be made to RHCF rates of payments applicable within the assessment period, based on a reconciliation of actual assessment payments to estimated payments.<sup>1</sup>

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<sup>1</sup>The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

**TN #09-03** \_\_\_\_\_

**Approval Date**           MAY 21 2009          

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Part I

Appendix 13 - Patient Categories and Case Mix Indices Under  
the Resource Utilization Group (RUG-II) Classification System

Patient Category	Case Mix Index
Special Care A	1.51
Special Care B	1.74
Heavy Rehabilitation A	1.57
Heavy Rehabilitation B	1.79
Clinically Complex A	.70
Clinically Complex B	1.18
Clinically Complex C	1.32
Clinically Complex D	1.64
Severe Behavioral A	.69
Severe Behavioral B	1.03
Severe Behavioral C	1.25
Reduced Physical Functioning A	.55
Reduced Physical Functioning B	.83
Reduced Physical Functioning C	1.03
Reduced Physical Functioning D	1.17
Reduced Physical Functioning E	1.41

NY 87-7  
Supersedes

Approval date FEB 21 1989

86-4

Effective date JAN 1 1987

NEW YORK  
-112-

Attachment 4.19-0  
Part i

Appendix 13 (a) - Schedule of Allowances for Operators, Administrators, and Assistant Administrators Effective for the Base Year Ending 12/31/83

BEDS	TOTAL ALLOWANCE	INDIVIDUAL ALLOWANCE
1-40	\$20,690	
45	23,280	
50	25,870	
55	28,460	
60	31,050	
65	33,640	
70	36,230	
75	38,820	
80	41,410	\$36,970
85	44,000	37,930
90	46,590	38,890
95	49,180	39,850
100	51,770	40,810
110	54,360	41,770
120	56,950	42,730
130	59,540	43,690
140	62,130	44,650
150	64,720	45,610
160	67,310	46,570
170	69,900	47,530
180	72,490	48,490
190	75,080	49,450
200	77,670	50,410
210	80,260	51,370
220	82,850	52,330
230	85,440	53,290
240	88,030	54,250
250	90,620	55,210
260	93,210	56,170
270	95,800	57,130
280	98,390	58,090
290	100,980	59,050
300	103,570	60,010
310	106,160	60,970
320	108,750	61,930
		62,890

To determine the salary allowance for facilities with bed capacities not listed above, use the following amounts:

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NEW YORK

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Attachment 4.19-0  
Part I

BEDS	TOTAL	BEDS	INDIVIDUAL
41-100	\$518 per bed	76-100	\$192 per bed
100 & over	259 per bed	101 & over	96 per bed
Maximum 79,707			

NY 87-7  
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[Appendix 13(b)]

Counties and Regions

<u>Region</u>	<u>Counties in region</u>
ALBANY	Albany, Columbia, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Fulton
BINGHAMTON	Broome, Tioga
ERIE	Cattaraugus, Chautauqua, Erie, Niagara, Orleans
ELMIRA	Chemung, Steuben, Schuyler
GLENS FALLS	Essex, Warren, Washington
LONG ISLAND	Nassau, Suffolk
ORANGE	Chenango, Delaware, Orange, Otsego, Sullivan, Ulster
NEW YORK CITY	Bronx, Kings, Queens, Richmond, New York
POUGHKEEPSIE	Dutchess, Putnam
ROCHESTER	Livingston, Monroe, Ontario, Wayne
CENTRAL RURAL	Cayuga, Cortland, Seneca, Tompkins, Yates
SYRACUSE	Madison, Onondaga
UTICA	Herkimer, Jefferson, Lewis, Oneida, Oswego
WESTCHESTER	Rockland, Westchester
NORTHERN RURAL	Clinton, Franklin, Hamilton, St. Lawrence
WESTERN RURAL	Allegany, Genesee, Wyoming

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Supersedes TN 87-7 Effective Date JAN 1 - 1991

# PATIENT REVIEW INSTRUMENT (PRI)

## ADMINISTRATIVE DATA

<b>1 OPERATING CERTIFICATE NUMBER</b> <input type="text"/>	<b>2 SOCIAL SECURITY NUMBER</b> <input type="text"/>
<b>3 RESIDENT IS LOCATED</b> 1 = Former HRF Area 2 = Former SNF Area <input type="checkbox"/>	<b>11 DATE OF INITIAL ADMISSION</b> to this facility (NF) (first admission not most recent) <input type="text"/>
<b>4 PATIENT NAME (PLEASE PRINT)</b> <input type="text"/>	<b>12 MEDICAID NUMBER</b> <input type="text"/>
<b>5 DATE OF PRI COMPLETION</b> <input type="text"/>	<b>13 MEDICARE NUMBER</b> <input type="text"/>
<b>6 MEDICAL RECORD NUMBER</b> <input type="text"/>	<b>14 PRIMARY PAYOR</b> 1 = Medicaid    3 = Other 2 = Medicare <input type="checkbox"/>
<b>7 ROOM NUMBER</b> <input type="text"/>	<b>15 A REASON FOR PRI COMPLETION</b> 1 - Biannual Full Facility Cycle 2 - Quarterly New Admission Cycle <b>15A</b> <input type="checkbox"/>
<b>8 UNIT NUMBER (Assigned by RUG II Project)</b> <input type="text"/>	<b>15 B Was a PRI submitted by your facility (NF) for this patient during a previous full facility or a new admit cycle?</b> 1 = Yes    2 = No <b>15B</b> <input type="checkbox"/>
<b>9 DATE OF BIRTH</b> <input type="text"/>	
<b>10 SEX</b> 1 = Male 2 = Female <input type="checkbox"/>	

## I. MEDICAL EVENTS

**6 DECUBITUS LEVEL:** ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS

**7 MEDICAL CONDITIONS:** DURING THE PAST FOUR WEEKS. READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS. 1 = Yes    2 = No

- A. Comatose
- B. Dehydration
- C. Internal Bleeding
- D. Stasis Ulcer
- E. Terminally Ill
- F. Contractures
- G. Diabetes Mellitus
- H. Urinary Tract Infection
- I. Infection Symptomatic
- J. Accident
- K. Ventilator Dependent

## 18 MEDICAL TREATMENTS: READ THE INSTRUCTIONS FOR QUALIFIERS. 1 = Yes    2 = No

- A. Tracheostomy Care/Suctioning (Daily — Exclude self care)
- B. Suctioning — General (Daily)
- C. Oxygen (Daily)
- D. Respiratory Care (Daily)
- E. Nasal Gastric Feeding
- F. Parenteral Feeding
- G. Wound Care
- H. Chemotherapy
- I. Transfusion
- J. Dialysis
- K. Bowel and Bladder Rehabilitation (SEE INSTRUCTIONS)
- L. Catheter (Indwelling or External)
- M. Physical Restraints (Daytime Only)

**III. ACTIVITIES OF DAILY LIVING (ADLs)****19 EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE PLATE, CUP, TUBE)**

- 1 = Feeds self without supervision or physical assistance. May use adaptive equipment.
- 2 = Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or *minimal* physical assistance with major parts of eating, such as cutting food, buttering bread or opening milk carton.
- 3 = Requires continual help (encouragement/teaching, physical assistance) with eating or meal will not be completed.
- 4 = Totally fed by hand; patient does not manually participate.
- 5 = Tube or parenteral feeding for primary intake of food (Not just for supplemental nourishments).

**20 MOBILITY: HOW THE PATIENT MOVES ABOUT**

- 1 = Walks with no supervision or human assistance. May require mechanical device (for example, a walker) but not a wheelchair.
- 2 = Walks with *intermittent* supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).
- 3 = Walks with *constant* one-to-one supervision and/or constant physical assistance.
- 4 = *Wheels* with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.
- 5 = Is *wheeled* in chair or bed. Relies on someone else to move about, if at all.

**21 TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS TO/FROM BED, CHAIR, STANDING (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET)**

- 1 = Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.
- 2 = Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.
- 3 = Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.
- 4 = Requires *two* people to provide constant supervision and/or physically lift. May need lifting equipment.
- 5 = Cannot and is not gotten out of bed.

**22 TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN), TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES**

- 1 = Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.
- 2 = Requires *intermittent* supervision for safety or encouragement; or *minor* physical assistance (for example, clothes adjustment or washing hands).
- 3 = Continent of bowel and bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, including appliances (i.e., colostomy, ileostomy, urinary catheter).
- 4 = Incontinent of bowel and/or bladder and is not taken to a bathroom.
- 5 = Incontinent of bowel and/or bladder but is taken to a bathroom every two to four hours during the day and as needed at night.

**IV. BEHAVIORS****23 VERBAL DISRUPTION: BY YELLING, BAITING, THREATENING, ETC**

- 1 = None during the past four weeks. (May have verbal outbursts which are not disruptive.)
- 2 = Verbal disruption one to three times during the past four weeks.
- 3 = Short-lived disruption at least once per week during the past four weeks or *predictable* disruption regardless of frequency (for example, during specific care routines, such as bathing).
- 4 = Unpredictable, recurring verbal disruption at least once per week for no foretold reason.
- 5 = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

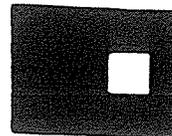
**24 PHYSICAL AGGRESSION: ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH INTENT FOR INJURY. (FOR EXAMPLE HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR)**

- 1 = None during the past four weeks.
- 2 = Unpredictable aggression during the past four weeks (whether mild or extreme) but *not* at least once per week.
- 3 = Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into) regardless of frequency. May strike or fight.
- 4 = Unpredictable, recurring aggression at least once per week during the past four weeks for no apparent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).
- 5 = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).



**18 RACE/ETHNIC GROUP:** ENTER THIS CODE WHICH BEST DESCRIBES THE PATIENT'S RACE OR ETHNIC GROUP

- |                    |  |  |
|--------------------|--|--|
| 1 = White          | 4 = Black/Hispanic                     | 7 = American Indian or Alaskan Native          |
| 2 = White/Hispanic | 5 = Asian or Pacific Islander          | 8 = American Indian or Alaskan Native/Hispanic |
| 3 = Black          | 6 = Asian or Pacific Islander/Hispanic | 9 = Other                                      |



TN 91-25 Effective Date JUL 11 1984  
Supersedes TN 89-4 Effective Date APR 1 - 1991

NEW YORK STATE DEPARTMENT OF HEALTH  
DIVISION OF HEALTH CARE FINANCING

INSTRUCTIONS: PATIENT REVIEW INSTRUMENT (PRI)

GENERAL CONCEPTS

1. **USING THESE INSTRUCTIONS:** These instructions and the training manual should be read before completing the PRI. These instructions should be kept with the PRIs as they are being completed. **FREQUENT REFERENCE TO THE INSTRUCTIONS WILL BE NEEDED TO COMPLETE THE PRI ACCURATELY.**
2. **ANSWER ALL QUESTIONS:** Answer all questions using the numeric codes provided. **DO NOT LEAVE ANY QUESTIONS TOTALLY BLANK. UNUSED BOXES FOR A QUESTION SHOULD REMAIN BLANK.** For example, Medical Record Number should be entered: / / 9 / 6 / 2 / 1 / 0 /. If there are unused boxes, they should be on the left side of the number as shown in the example.
3. **QUALIFIERS:** Many of the PRI questions contain multiple criteria which are labeled qualifiers. All qualifiers must be met for a question to be answered yes. These qualifiers take the following forms:
  - **TIME PERIOD** - The time period for the questions is the past four weeks, unless stated otherwise. For patients who have been in the facility less than four weeks (that is, new admissions or readmissions), use the time from admission to PRI completion as the time frame.
  - **FREQUENCY** - The frequency specifies how often something needs to occur to meet the qualifier. For example, respiratory care needs to occur daily for four weeks or the PRI cannot be checked for this patient as receiving this care.
  - **DOCUMENTATION** - Some of the questions require specific medical record documentation to be present. Otherwise, the question cannot be answered "yes" for the patient.
  - **EXCLUSIONS** - Some of the questions specifically state to omit certain types of care or behavior when answering the question. For example, inhalators are excluded from respiratory care.
4. **ACTIVITIES OF DAILY LIVING:** The approach to measuring ADLs is slightly different from the other PRI questions. Measure the ADLs according to how the activity was completed 60% or more of the time during the past four weeks. Read the specific instructions for ADLs to understand the **CHANGED CONDITION RULE** and other details. **PERFORMANCE:** Measure what the patient does, rather than what the patient might be capable of doing.
5. **CORRECTIONS:** Cross out any responses which you wish to change and re-enter clearly to the right of the original response. Example: /3/ 4.
6. Use pen, not pencil.

TN 99-34 Approval Date DEC 30 1999

Supersedes TN 91-25 Effective Date JUL 1 1999

## INSTRUCTIONS: PRI QUESTIONS

### I. ADMINISTRATIVE DATA

1. **OPERATING CERTIFICATE NUMBER:** Enter the 8 character identifier (7 numbers followed by the letter "N") stated on the facility's operating certificate. The last character "N" indicates Nursing Facility.
2. **SOCIAL SECURITY NUMBER:** Your PRIs can not be processed unless this question is accurately entered. Do not leave this question blank, do not enter zero if there is no social security number. Only use the Social Security number that has been specifically designated for the patient and not the spouse of the patient. Only use the number that has been assigned by the federal Social Security Administration. If there is no such number for a patient, a NEW SYSTEM has been developed to enable all facilities in the State to assign a unique ID number to those patients without a Social Security number. If a patient was assigned a computer generated number by the Department, that number should no longer be used. If the patient has no Social Security number, use this method: Enter the first three (3) letters of the patient's last name (starting to the far left), and then enter the six digits of the patient's date of birth. Omit the century in the birth date, which will be either a "19" or "18" as in 1930 or 1896. As an example, if a patient named Cheryl Brant has no social security number and was born on May 8, 1913, you would enter:/B/R/A/0/5/0/8/1/3 on the PRI.
3. **RESIDENT IS LOCATED:** Former HRF Area or Former SNF Area. This question has been revised to reflect the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). It is imperative that nursing facilities formerly deemed "dual level" complete this section properly.
4. **PATIENT NAME:** Enter the patient's name, last name first, in the boxes provided. Enter up to the first 10 letters of the patient's last name.
6. **MEDICAL RECORD NUMBER:** Enter the unique number assigned by the facility to identify each patient. It is not the Medicaid, Medicare or Social Security number unless that is the number used by the facility to identify each of its patients.
7. **ROOM NUMBER:** Enter the numbers and/or letters which identify the patient's room in the facility.
8. **UNIT NUMBER:** Enter the one or the two digit number (01-12) assigned by your facility to each nursing unit for the purpose of this data collection.
11. **DATE OF INITIAL ADMISSION:** Enter the month, day and year the patient (1) entered the present nursing facility. Use the date of the patient's first admission and not the most recent. If the patient were transferred from another facility, it would be an initial admission to your facility. As another example, consider a patient that was admitted to a hospital from your facility and subsequently loses bed hold. If this patient is eventually readmitted to your facility at the original level of care, use the original admission date to complete this item.

12. **MEDICAID NUMBER:** Enter these numbers if patient has the coverage available, whether <sup>DEC 30 1991</sup>

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Page 2 of 2 of TN \_\_\_\_\_

13. **MEDICARE NUMBER:** or not the coverage is being used. If not, enter only one zero in the far right box.
14. **PRIMARY PAYOR:** Enter the one source of coverage which pays for most of the patient's current nursing home stay. Code "Other" only if the primary payor is not Medicaid or Medicare. (Do not code "Other" for a patient with Medicaid coverage supplemented by Medicare Part B Code Medicaid.) Medicaid pending is to be coded as "Medicaid", if there is no other primary coverage being used for the patient's present stay.
- 15A. **REASON FOR PRI COMPLETION:** Select the one reason why the PRI is being completed. Responses 3, 4, and 5 under Utilization Review have been eliminated.

**REIMBURSEMENT ASSESSMENT CYCLE:**

Indicate whether this assessment is being completed as a part of a full facility assessment or as part of a quality assessment cycle for new admissions only.

1. **Biannual Full Facility Cycle** - The data collection during which all the patients residing in the facility are assessed. These PRI assessments include patients who were assessed during your previous PRI data collection and any new admissions.
  2. **Quarterly New Admission Cycle** - The "new admission only data collection," involving only patients who were not assessed at their present level of care during your previous full facility data collection are reviewed. This specific PRI data collection occurs three months after your full facility PRI data collection. A new admission may be a new patient from the hospital, community or another nursing facility; or was hospitalized during your previous full facility assessment (regardless of bedhold).
- 15B. **WAS A PRI SUBMITTED BY YOUR FACILITY FOR THIS PATIENT DURING A PREVIOUS FULL FACILITY AND/OR NEW ADMIT CYCLE:** Review your facility's records to determine whether a PRI for reimbursement purposes was ever completed for this patient.

**II. MEDICAL EVENTS**

16. **DECUBITUS LEVEL:** Enter the level of skin breakdown (located at pressure points) using the qualifiers stated below:

Documentation- For a patient to be cited as level 4, documentation by a licensed clinician must exist which describes the following three components:

- o A description of the patient's decubitus.
- o Circumstance or medical condition which led to the decubitus.
- o An active treatment plan.

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Supersedes TN 11-25 Effective Date JUL 1 1999

**Definition LEVELS:**

- #0 No reddened skin or breakdown.
- #1 Reddened skin, potential breakdown.
- #2 Blushed skin, dusty colored, superficial layer of broken or blistered skin.
- #3 Subcutaneous skin is broken down.
- #4 Necrotic breakdown of skin and subcutaneous tissue which may involve muscle, fascia and bone.
- #5 Patient is a level 4, but the documentation qualifier has not been met.

**17. MEDICAL CONDITIONS:** For a "YES" to be answered for any of these conditions, all of the following qualifiers must be met:

- Time Period-** Condition must have existed during the past four weeks. (The only exception is to use the past twelve weeks for question 17H, urinary tract infection.)
- Documentation-** Written support exists that the patient has the condition.
- Definitions-** See chart below. (Examples are for clarification and are not intended to be all-inclusive.)

	DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
17A.	<b>COMATOSE:</b> Unconscious, cannot be aroused, and at most can respond only to powerful stimuli. The coma must be present for at least four days.	Brain insult Hepatic encephalopathy Cerebral vascular accident	Total ADL Care Intake and output Parenteral feeding
17B.	<b>DEHYDRATION:</b> Excessive loss of body fluids requiring immediate medical treatment and ADL care.	Fever Acute urinary tract infections Pneumonia Vomiting Unstable diabetes	Intake & output Electrolyte lab tests Parenteral hydration Nasal Feedings
17C.	<b>INTERNAL BLEEDING:</b> Blood loss stemming from a subacute or chronic condition (e.g., gastrointestinal, respiratory or genito-urinary conditions) which may result in low blood pressure and hemoglobin, pallor, dizziness, fatigue, rapid respiration.	Use only the causes presented in the definition. Exclude external hemorrhoids and other minor blood loss which is not dangerous and requires only minor intervention	Critical monitoring of vital signs Transfusion Use of blood pressure elevators Plasma expanders Blood likely to be needed every 60 day

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	DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
17D.	<b>STASIS ULCER:</b> Open lesion, usually in lower extremities, caused by decreased blood flow from chronic venous insufficiency.	Severe edema Diabetes PVD	Sterile dressing Compresses Whirlpool Leg elevation
17E.	<b>TERMINALLY ILL:</b> Professional prognosis (judgement) is that patient is rapidly deteriorating and will likely die within three months.	End stages of: Carcinoma, Renal disease, and Cardiac diseases	ADL Care Social/emotional support
17F.	<b>CONTRACTURES:</b> Shortening and tightening of ligaments and muscles resulting in loss of joint movement. Determine whether range of motion loss is actually due to spasticity, paralysis or joint pain. It is important to observe the patient to confirm whether a contracture exists and check the chart for confirmatory documentation.		

To qualify as "YES" on the PRI the following qualifiers must be met:

1. The contracture must be documented by a physician, physical therapist or occupational therapist.
2. The status of the contracture must be reevaluated and documented by the physician, physical therapist or occupational therapist on an annual basis.

There does not need to be an active treatment plan to enter "YES" to contractures.

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Supersedes TN 91-25 Effective Date JUL 1 1999

	DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
17G.	<b>DIABETES MELLITUS:</b> A metabolic disorder in which the ability to oxidize carbohydrates is compromised due to inadequate pancreatic activity resulting in disturbance of normal insulin production. This may or may not be the primary problem (Q. 29) or primary diagnosis. It should be diagnosed by a physician. Include any degree of diabetes, stable or unstable, and any manner it is controlled.	Destruction/malfunction of the pancreas Exclude hypoglycemia or hyperglycemia which may be a diabetic condition, but by itself does not constitute diabetes mellitus	Special diet Oral agents Insulin Exercise
17H.	<b>URINARY TRACT INFECTION:</b> During the past twelve weeks symptoms of a UTI have been exhibited or it has been diagnosed by lab tests. Symptoms may include frequent voiding, foul smelling urine, voiding small amounts cloudy urine, sediment and an elevated temperature. May or may not be the primary problem under Q.29. Include as a UTI if it has not been confirmed yet by lab tests, but the symptoms are present. Include patients who appear asymptomatic, but whose lab values are positive (e.g., mentally confused or incontinent patients).	Exclude if symptoms are present, but the lab values are negative	Antibiotics Fluids

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	DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
17I.	<p>HIV INFECTION SYMPTOMATIC: HIV (Human Immunodeficiency Virus) Infection, Symptomatic: Includes Acquired Immunodeficiency Syndrome (AIDS) and HIV related illnesses. The patient has been tested for HIV infection AND a positive finding is documented AND the patient has had symptoms, documented by a physician, <u>nurse practitioner (in conformance with a written practice agreement with a physician), or physician assistant as related to the HIV infection.</u> Symptoms include but are not limited to abnormal weight loss, respiratory abnormalities, anemia, persistent fever, fatigue and diarrhea. Symptoms need not have occurred in the past four weeks. Exclude patients who have tested positive for HIV infection and have not become symptomatic, and patients who have not received the results of the HIV test.</p>		
17J.	<p>ACCIDENT: An event resulting in serious bodily harm, such as a fracture, a laceration which requires closure, a second or third degree burn or an injury requiring admission to a hospital.</p> <p>To qualify as "YES" on the PRI the following qualifier must be met:</p> <ol style="list-style-type: none"><li>1. During the past six months serious bodily harm occurred as the result of one or more accidents.</li></ol>		

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DEFINITION

EXAMPLES OF CAUSES

EXAMPLES OF TREATMENTS

17K. VENTILATOR DEPENDENT: A patient who has been admitted to a skilled nursing facility on a ventilator or has been ventilator dependent within five (5) days prior to admission to the skilled nursing facility. Patients who are in the process of being weaned off of ventilator support will qualify for this category for one month after extubation if they are receiving active respiratory rehabilitation services during that period. Patients in the facility who decompensate and require intubation also qualify for this category.

All services shall be Provided in accordance with Sections 416.13, 711.5 and 713.21 of Chape V of Title 10 of the *Official Compilation of Codes Rules and Regulations* of the State of New York.

18. MEDICAL TREATMENTS: For a "YES" to be answered for any of these, the following qualifiers must be met:

Time Period-	Treatment must have been given during the past four weeks <u>in conformance with the frequency requirements cited below and is still be required. For medical treatments having a daily frequency requirement, treatment must be provided every day of the four week period, except for residents newly admitted during the period. For residents newly admitted during the four week period, treatments required daily must have been provided each day from admission to the end of the four week period and documentation must support the seriousness of the condition and the probability that treatment will continue for at least four weeks.</u>
Frequency-	As specified in the chart below. (The only exception is to use the past twelve weeks for question 18L, catheter.)
Documentation-	Physician <u>order, nurse practitioner order (in conformance with a written practice agreement with a physician), or appropriately cosigned physician assistant order</u> specifies that treatment should be given and includes frequency as cited below, where appropriate.
Exclusions-	See chart on next page.

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 Supersedes TN 91-25 Effective Date JUL 1 1999  
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	DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
18A.	TRACHEOSTOMY CARE: Care for a tracheostomy, including suctioning. Exclude any self-care patients who do not need daily staff help.	Daily	Self-care patients
18B.	SUCTIONING: Nasal or oral techniques for clearing away fluid or secretions. May be for a respiratory problem.	Daily	Any tracheostomy Suctioning
18C.	OXYGEN THERAPY: Administration of oxygen by nasal catheter, mask (nasal or oronasal), funnel/cone, or oxygen tent for conditions resulting from oxygen deficiency (e.g., cardiopulmonary condition).	Daily	Inhalators Oxygen in room, but not in use
18D.	RESPIRATORY CARE: Care for any portion of the respiratory tract, especially the lungs (for example COPD, pneumonia). This care may include one or more of the following: percussion or cupping, postural drainage, positive pressure machine, possibly oxygen to administer drugs, etc.	Daily	Suctioning
18E.	NASAL GASTRIC FEEDING: Primary food intake is by a tube inserted into nasal passage; resorted to when it is the only route to the stomach.	None	None Gastrostomy not applicable
18F.	PARENTERAL FEEDING: Intravenous or subcutaneous route for the administration of fluids used to maintain fluid, nutritional intake, electrolyte balance (e.g., comatose, damaged stomach).	None	None Gastrostomy not applicable
18G.	WOUND CARE: Subcutaneous lesion(s) resulting from surgery, trauma, or open cancerous ulcers.	Care has been provided or is professionally judged to be needed for at least 3 consecutive weeks	Decubiti Stasis ulcers Skin tears Feeding tubes

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	DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
18H.	CHEMOTHERAPY: Treatment of carcinoma through IV and/or oral chemical agents, as ordered by a physician, <u>nurse practitioner, (in conformance with a written practice agreement with a physician), or physician assistant when the physician assistant's order is appropriately cosigned.</u> (Patient may have to go to a hospital for treatment.)	None	None
18I.	TRANSFUSIONS: Introduction of whole blood or blood components directly into the blood stream. (Patients may have to go to a hospital for treatment.)	None	None
18J.	DIALYSIS: The process of separating components, as in kidney dialysis (e.g., renal failures, leukemia, blood dyscrasia). Patient may have to go to a hospital for treatment.	None	None
18K.	BOWEL AND/OR BLADDER REHABILITATION: The goal of this treatment to gain or regain optimal bowel and/or bladder function and to re-establish a pattern. It is much more than just a toileting schedule or a maintenance/conditioning program. Rather it is an intense treatment which is very specific and unique for each patient and is of short term duration (i.e., usually not longer than six weeks). NOT all patients at level 5 under Toileting Q.22 may be a "YES" with this question. The specific definition for bladder rehabilitation differs from bowel rehabilitation; refer below:	Very specific And unique for each patient	Maintenance toileting schedule Restorative toileting program but does not meet the treatment requirements specified in the definitions

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**DEFINITION**

**SPECIFIC  
FREQUENCY**

**EXCLUSIONS**

Bladder rehabilitation: Will generally include these step-by-step procedures which are closely monitored, evaluated and documented: (1) mental and physical assessment of the patient to determine training capacity; (2) a 24 hour flow sheet or chart documenting voiding progress; (3) possibly increased fluid intake during the daytime; (4) careful attention to skin care; (5) prevention of constipation; (6) in the beginning may be toileted 8 to 12 times per day with decreased frequency with progress.

Bowl rehabilitation: A program to prevent chronic constipation/impaction. The plan will generally include: (1) assessment of past bowel movements, relevant medical problems, medication use; (2) a dietary regimen of increased fluids and bulk (e.g., bran, fruits); (3) regular toileting for purposes of bowel evacuation; (4) use of glycerine suppositories or laxatives; (5) documentation on a worksheet or Kardex.

Exclude a bowel maintenance program which controls bowel intinence by development of a routine bowel schedule

18L. **CATHETER:** During the past twelve weeks, an indwelling or external catheter has been needed. Indwelling catheter has been used for any duration during the past twelve weeks. The external catheter was used on a continuous basis (with proper removal and replacement during this period) for one or more days during the past twelve weeks. A physician order is required for an indwelling catheter; for an external catheter a physician order is not required:

Exclude catheters used to empty the bladder once, secure a specimen or instill medication

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**DEFINITION**

**SPECIFIC  
FREQUENCY**

**EXCLUSIONS**

18M.	<p><b>PHYSICAL RESTRAINTS:</b> A physical device used to restrict resident movement. Physical restraints include belts, vests, cuffs, mitts, jackets, harnesses and geriatric chairs.</p>	<p>At least two continuous Daytime hours for at least 14 days during the past four weeks.</p>	<p>Exclude all of following:</p> <ul style="list-style-type: none"> <li>◦ Medication use for the sole purpose of modifying residents behavior</li> <li>◦ Application only at night</li> <li>◦ Application for less than two continuous daytime hours for 14 days</li> <li>◦ Devices which residents can release/remove such as, velcro seatbelts on wheelchairs</li> <li>◦ Residents who are bed bound</li> <li>◦ Side rails, locked doors/gates, domes</li> </ul>
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To Qualify as "YES" on the PRI the following qualifiers must be met:

1. The restraint must have been applied for at least two continuous daytime hours for at least 14 days during the past four weeks. Daytime includes the time from when the resident gets up in the morning to when the resident goes to bed at night.
2. An assessment of need for the physical restraint must be written by an M.D. or R.N.
3. The comprehensive care plan based on the assessment must include a written physician's order and specific nursing interventions regarding use of the physical restraint.

**NEW ADMISSIONS:** If a patient is a new admission and will require the use of a physical restraint for at least two continuous daytime hours for at least 14 days as specified by the physician order, then enter "YES" on the PRI.

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### III. ACTIVITIES OF DAILY LIVING: EATING, MOBILITY, TRANSFER, TOILETING

Use the following qualifiers in answering each ADL question:

Time Period- Past four weeks.  
Frequency- Asses how the patient completed each ADL 60% or more of the time performed (since ADL status may fluctuate during the day or over the past four weeks.)

**CHANGED CONDITION RULE:** When a patient's ADL has improved or deteriorated during the past four weeks and this course is unlikely to change, measure the ADL according to its status during the past seven days.

Definitions- **SUPERVISION** means verbal encouragement and observation, not physical hands-on care.

**ASSISTANCE** means physical hands-on care.

**INTERMITTENT** means that a staff person does not have to be present during the entire activity, nor does the help have to be on a one-to-one basis.

**CONSTANT** means one-to-one care that requires a staff person to be present during the entire activity. If the staff person is not present, the patient will not complete the activity.

Note how these terms are used together in the ADLs. For example, there is intermittent supervision and intermittent assistance.

### CLARIFICATION OF ADL RESPONSES

#### 19. EATING:

#3 "Requires continual help..." means that the patient requires a staff person's continual presence and help for reasons such as: patient tends to choke, has a swallowing problem, is learning to feed self, or is quite confused and forgets to eat.

#5 "Tube or parenteral feeding..." means that all food and drink is given by nursing staff through the means specified.

#### 20. MOBILITY:

#3 "Walks with constant supervision and/or assistance..." may be required if the patient cannot

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maintain balance, has a history of falls, has stress fracture potential, or is relearning to ambulate.

21. TRANSFER: Exclude transfers to bath or toilet.

#4 "Requires two people..." may be required for reasons such as: the patient is obese, has contractures, has fractures (or stress fracture potential), has attached equipment that makes transfer difficult (for example, tubes). There must be a logical medical reason why the patient needs the help of two people to transfer.

#5 "Bedfast..." may refer to a patient with acute dehydration, severe decubitus, or terminal illness.

22. TOILETING:

Definition - INCONTINENT - 60% or more of the time the patient loses control of his/her bladder or bowel functions, with or without equipment.

#1 "Continent... Requires no or intermittent supervision" and #2 "... and/or assistance" can refer to the continent patient or the incontinent patient who needs no/little help with his/her toileting equipment (for example, catheter).

#3 "Continent... Requires constant supervision/total assistance..." refers to a patient who may not be able to balance him/herself and transfer, has contractures, has fracture, is confused or is on a rehabilitation program. In addition this level refers to the patient who needs constant help with elimination/incontinence appliances (for example, colostomy, ileostomy).

#4 "Incontinent... Does not use a bathroom" refers to the patient who does not go to a toilet room, but instead may use a bedpan or continence pads. This patient may be bed bound or mentally confused to the extent that a scheduled toileting program is not beneficial.

#5 "Incontinent... Taken to a Bathroom..." refers to a patient who is on a formal toileting schedule, as documented in the medical record. This patient may be on a formal bowel and bladder rehabilitation program to regain or maintain control, or the toileting pattern is known and it is better psychologically and physically for the patient to be taken to the toilet (for example, to prevent decubiti).

A patient may have different levels of toileting capacity for bowel and bladder function. To determine the level of such a patient, note that level four and five refer to incontinence of either bladder or bowel. Thus if a patient receives the type of care described in one of these levels for either type of incontinence, enter that level.

Example 1:

A Patient needs constant assistance with a catheter (level 3) and is incontinent of bowel and is taken to the bathroom every four hours (level 5). In this instance, enter level 5 on the PRI because he is receiving the type of care described in this question for bowel incontinence.

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Example 2: The patient requires intermittent supervision for bowel function (level 2) and is taken to the toilet every two hours as part of a bladder rehabilitation program. Enter level 5, as the patient is receiving this type of care for bladder incontinence.

**IV. BEHAVIORS - VERBAL DISRUPTION; PHYSICAL AGGRESSION; DISRUPTIVE, INFANTILE/SOCIALY INAPPROPRIATE BEHAVIOR; AND HALLUCINATIONS**

The following qualifiers must be met:

Time Period- Past four weeks.

Frequency- As stated in the responses to each behavioral question.

Documentation- To qualify a patient as LEVEL 4 or to qualify the patient as a "YES" to HALLUCINATIONS, the following conditions must be met:

- o Active treatment plan for the behavioral problem must be in current use.
- o Psychiatric assessment by a recognized professional with psychiatric training/education must exist to support the fact that the patient has a severe behavioral problem. The problem addressed by this assessment must still be exhibited by the patient.

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Definitions-

The terms used on the PRI should be interpreted only as they are defined below:

- **PATIENT'S BEHAVIOR:** Measure it as displayed with the behavior modification and treatment plan in effect during the past four weeks.
- **DISRUPTION:** Through verbal outbursts and/or physical actions, the patient interferes with the staff and/or other patients. This interference causes the staff to stop or change what they are doing immediately to control the situation. Without this staff assistance, the disruption would persist or a problem would occur.
- **NONDISRUPTION:** Verbal outbursts and/or physical actions by the patient may be irritating, but do not create a need for immediate action by the staff.
- **UNPREDICTABLE BEHAVIOR:** The staff cannot predict when (that is, under what circumstances) the patient will exhibit the behavioral problem. There is no evident pattern.
- **PREDICTABLE BEHAVIOR:** Based on observations and experiences with the patient, the staff can discern when a patient will exhibit a behavioral problem and can plan appropriate responses in advance. The behavioral problem may occur during activities of daily living (for example, bathing), specific treatments (for example, contracture care, ambulation exercises), or when criticized, bumped into, etc.

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**CLARIFICATION OF RESPONSES TO BEHAVIORAL QUESTIONS**

- 23. **VERBAL DISRUPTION:** Exclude verbal outbursts/expressions/utterances which do not create disruption as defined by the PRI.
- 24. **PHYSICAL AGGRESSION:** Note that the definition states "with intent for injury."
- 25. **DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR:** Note that the definition states this behavior is physical and creates disruption.  
EXCLUDE the following behaviors:

- Verbal outbursts
- Social withdrawal
- Hoarding
- Paranoia

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26. HALLUCINATIONS: For a "YES" response, the hallucinations must occur at least once per week during the past four weeks, in addition to meeting the other qualifiers noted above for an active treatment plan and psychiatric assessment.

V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES:

- For each therapy these three types of information will be entered on the PRI; "Level", "Days" and "Time" (hour and minutes).
- For a patient not receiving a therapy at all, the "Level" will always be entered in the answer key as #1 ("does not receive"), the "Days" will be entered 0 (zero) and the "Time" will be 0 (zero).
- Use the chart on the following page to understand the qualifiers for each of the three types of information that will be entered. Whether a patient is receiving maintenance or restorative therapy will make a difference in terms of the qualifiers to be used.

SEE CHART THAT FOLLOWS FOR THE SPECIFIC QUALIFIERS.

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27. \*LEVEL QUESTION:

\*\*QUALIFIERS (see level 4 below)

QUALIFIERS FOR LEVEL

MAINTENANCE THERAPY =  
LEVEL 2

RESTORATIVE THERAPY =  
LEVEL 3

DOCUMENTATION  
QUALIFIERS: POTENTIAL FOR  
INCREASED FUNCTIONAL /  
ADL ABILITY

None.  
Therapy is provided to  
maintain and/or retard  
deterioration of current  
functional/ADL status.  
Therapy plan of care and  
progress notes should support  
that patient has no potential  
for further or any significant  
improvement.

There is positive potential for  
improved functional status  
within a short and predictable  
period of time. Therapy plan  
of care and progress notes  
should support that patient  
has this potential/is improving.

PHYSICIAN ORDER, NURSE  
PRACTITIONER ORDER (IN  
CONFORMANCE WITH A  
WRITTEN PRACTICE  
AGREEMENT WITH A  
PHYSICIAN), OR  
APPROPRIATELY COSIGNED  
PHYSICIAN ASSISTANT  
ORDER

Yes

Yes, monthly

PROGRAM DESIGN AND  
EVALUATION QUALIFIER

Licensed professional person  
with a 4 year, specialized  
therapy degree evaluates  
program on a monthly basis.

Licensed professional person  
with a 4 year, specialized  
therapy degree evaluates  
program on a monthly basis.

TIME PERIOD QUALIFIER

Treatments have been  
provided during the past four  
weeks.

Treatments have been  
provided during the past four  
weeks.

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27. \*LEVEL QUESTION:

\*\*QUALIFIERS (see level 4 below)

QUALIFIERS FOR LEVEL

MAINTENANCE THERAPY =  
LEVEL 2

RESTORATIVE THERAPY =  
LEVEL 3

NEW ADMISSION QUALIFIER

Not Applicable

New admissions of less than four weeks can be marked for restorative therapy if:

- o There is a physician order, nurse practitioner order (in conformance with a written practice agreement with a physician), or appropriately cosigned physician assistant order for therapy and patient is receiving it.
- o The licensed therapist has documented in the care/plan that therapy is needed for at least 4 weeks.
- o A new admission includes readmission to a residential health care facility.

\* After completion of the "Level" question, proceed to the separate "Days" and "Time" qualifiers on the next page.

\*\* QUALIFIERS NOT MET = LEVEL 4

ENTER LEVEL 4 IF ANY ONE OF THE QUALIFIERS UNDER QUALIFIERS FOR LEVELS 2 OR 3 IS NOT MET.

27. DAYS AND TIME PER WEEK QUESTION: QUALIFIERS\*

QUALIFIERS FOR DAYS AND TIME\*

MAINTENANCE THERAPY (i.e., level 2 or 4 under "Level" question)

RESTORATIVE THERAPY (i.e., If level 3 or 4 under "Level" question)

TYPE OF THERAPY SESSION

Count only one-to-one care. Exclude group sessions (e.g., PT exercise session, OT cooking session).

Count only one-to-one care. Exclude group sessions (e.g., PT exercise session, OT cooking session).

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**SPECIALIZED PROFESSIONAL ON-SITE (ON-SITE MEANS WITHIN THE FACILITY)**

A certified (2 year) or licensed (4 year) specialized professional is on-site supervising or providing therapy.

A licensed (4 year) specialized professional is on-site supervising or providing care. (Do not include care provided by PT or OT aides).

\* QUALIFIERS NOT MET: DO NOT ENTER ON THE IRI ANY DAYS AND TIME OF THERAPY WHICH DO NOT MEET BOTH THE QUALIFIERS UNDER EACH LEVEL OF THERAPY.

28. NUMBER OF PHYSICIAN VISITS: Enter "0" (zero) unless the patient need qualifiers stated below are met. If, and ONLY if, the patient meets all the patient need qualifiers, then enter the number of physician visits, nurse practitioner visits (in conformance with a written practice agreement with a physician), or physician assistant visits that meet the physician, nurse practitioner, or physician assistant visit qualifiers

- o PATIENT TYPE/NEED QUALIFIERS: The patient has a medical condition that (1) is unstable and changing or (2) is stable, but there is high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative).
- o PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT VISIT QUALIFIER: If, and only if, the patient meets the PATIENT TYPE/NEED QUALIFIER, then enter the number of physician visits, nurse practitioner visits (in conformance with a written practice agreement with a physician), or physician assistant visits during the past four weeks that meet the following qualifications:
  - o A visit qualifies only if there is physician, nurse practitioner, or physician assistant documentation that she/he has personally examined the patient to address the pertinent medical problem. The physician, nurse practitioner, or physician assistant must make a notation or documentation in the medical record as to the result of the visit for the unstable medical condition (e.g., change medications, renew treatment orders, nursing orders, order lab tests).
  - o Do not include phone calls as a visit nor visits which could have been accomplished over the phone.
  - o A visit qualifies whether it is on-site or off-site, as long as the patient is not an inpatient in a hospital/other facility.

29. MEDICATIONS

A. Monthly average number of all medications ordered: Enter the monthly average number of different medications for which physician orders were written over the course of the past six months. If the resident has been in the facility less than six months determine the monthly

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average number of medications ordered based on the number of months since admission. The average should include the total number of ordered medications whether or not they were administered: (PRN medications; injectables, ointments, creams, ophthalmics, short-term antibiotic regimens and over-the-counter medications, etc.)

- B. Monthly average number of psychoactive medications ordered: Enter the monthly average number of psychoactive medications for which physician orders were written over the course of the past six months. If the resident has been in the facility less than six months, determine the monthly average of psychoactive medications ordered based on the number of months since admission. The average should include all ordered psychoactive medications whether or not they were actually administered.

A "psychoactive" medication is defined as a medication that is intended to affect mental and/or physical processes, namely to sedate, stimulate, or otherwise change mood, thinking or behavior.

The following are classes of psychoactive medications with several examples listed in each:

- Antidepressants- Amitriptyline (Elavil); Imipramine (Tofranil); Doxepin (Sinequan); Tranylcypromine (Parnate); Phenelzine (Nardil)
- Anticholinergics- Benztropine (Cogentin); Trihexyphenidyl (Artane)
- Antihistamines- Diphenhydramine (Benadryl); Hydroxyzine (Atarax)
- Anxiolytics- Chlordiazepoxide (Librium); Diazepam (Valium)
- Cerebral Stimulants- Methylphenidate (Ritalin); Amphetamines (Benzedrine)
- Neuroleptics- Phenothiazines; Thiothixene (Navane); Haloperidol (Haldol); Chlorpromazine (Thorazine); Thioridazine (Mellaril)
- Somnifacients- Barbituates (Nembutal); Temazepam (Restoril); Glutethimide (Doriden); Flurazepam (Dalmane)

## VI. DIAGNOSIS

30. PRIMARY MEDICAL PROBLEM: Follow the guideline stated below when answering this question.

- NURSING TIME: The primary medical problem should be selected based on the condition that has created the most need for nursing time during the past four weeks. A review of the medical record for nursing and physician, nurse practitioner, or physician assistant notes during the past four weeks may be necessary.
- JUDGMENT: This decision may require the assessor to use her/his own professional judgment in deciding upon the primary problem.

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- ICD-9 Refer to the ICD-9 Codes for Common Diagnoses attached at the end of these instructions for easy access to the most frequently used numbers. An ICD-9 code book containing the complete ICD-9 listing should be available in the nursing and/or medical records office of a facility.
- NO ICD-9 NUMBER: Enter "0" (zero) in the far right box if no ICD-9 number can be found for the patient's primary problem (or if the patient does not have a primary medical problem). If you cannot locate the ICD-9 code for the primary medical problem, PRINT THE NAME OF THE PRIMARY MEDICAL PROBLEM in the space provided on the PRI.
- NOTE: If the patient has AIDS or HIV related illnesses, indicate this in Section II, Medical Events, Item 17F. Do not use AIDS or HIV specific ICD codes (042044). Instead, use the code of the specific problem requiring the most caregiver time. For example, for all patients for whom viral pneumonia (NOS) is the condition requiring the most caregiver time, enter 480.9. Do not enter 042.1 for patients with HIV infection.

31. **QUALIFIED ASSESSOR NUMBER:** The qualified assessor who is attesting to the accuracy of the assessment must sign the completed form and enter the assessor Identification Number which was assigned at an approved N.Y.S. Department of Health Training Program.

Since the PRI is completed and submitted for the purposes of a reimbursement assessment cycle, the certified assessor must have actually completed the patient assessment, utilizing medical records and/or observations or interviews of the patient. This should be indicated by checking the YES box.

38. **RACE/ETHNIC GROUP:**

~~The following definitions are to be utilized in determining race and ethnic groups.~~

1. **WHITE:** A person having origins in any of the original peoples of Europe, North Africa or the Middle East.
2. **WHITE/HISPANIC:** A person who meets the definition of both White and Hispanic (See Hispanic Below)
3. **BLACK:** A person having origins in any of the Black racial groups of Africa.
4. **BLACK/HISPANIC:** A person who meets the definition of both Black and Hispanic (see below).
5. **ASIAN OR PACIFIC ISLANDER:** A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.
6. **ASIAN or PACIFIC ISLAND/HISPANIC:** A person who meets the definition of both Asian or Pacific Islander and Hispanic (see below).

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7. AMERICAN INDIAN or ALASKAN NATIVE: A person having origins in any of the original peoples of North American and who maintains tribal affiliation or community recognition.
8. AMERICAN INDIAN or ALASKAN NATIVE/HISPANIC: A person who meets the definition of both American Indian or Alaskan Native and Hispanic (see below).
9. OTHER: Other groups not included in previous categories.

HISPANIC: A person of Puerto Rican, Mexican, Cuban, Dominican, Central or South American, or other Spanish Culture or origins.

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